PUBLIC HEALTH NURSING

DECEMBER
1949

TIME FOR *Thantis* LOZENGES

For throat irritations 'Thantis'* Lozenges provide effective relief. 'Thantis' Lozenges are especially beneficial in soothing these conditions because they are both antiseptic and anesthetic for mucous membranes of the throat and mouth. These effects are due to the two active medicinal agents, 'Merodicein'* an antiseptic of low toxicity, and Saligenin, a mild local anesthetic. When 'Thantis' Lozenges are dissolved in the mouth, the two ingredients dissolve slowly, providing prolonged medication of the throat.

Each lozenge contains 'Merodicein' (H. W. & D. brand of monohydroxymercuridiiodoresorcinsulfonphthalein-sodium) $\frac{1}{8}$ grain, Saligenin (orthohydroxybenzyl-alcohol, H. W. & D.) 1 grain.

Supplied in vials of 12 lozenges in individual cartons packed in dozens.

*Reg. U. S. Pat. Off.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND

Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.

PUBLIC HEALTH NURSING

VOL. 41, No. 12 DECEMBER 1949

CONTENTS

PUBLIC HEALTH NURSING

Editor: MARY EDWARDS SHAW *Assistant Editor:* HEDWIG COHEN, R.N.

 Published monthly. Entered as second class matter April 1, 1932 at the Post Office at Utica, New York, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage as provided for in Section 1103, Act of October 3, 1917 authorized August 27, 1918.

Subscription rates of PUBLIC HEALTH NURSING for United States and possessions, the Americas and Mexico, are $4.00 per 1 year and $6.50 per 2 years (subscription rate to NOPHN members, 1 year $3.00). Foreign and Canadian add 50 cents per year. Single copies 45 cents. Rate in combination with *American Journal of Nursing*, $6.50 per 1 year. Rate in combination with *The Survey*, $7.75.

Saunders Books

American Nurses Dictionary

Here's a Christmas present that will really be appreciated by every one of your friends in the nursing profession. This *different* dictionary was written specifically for nurses by a nurse. It includes all the words the nurse needs to know—and defines them in the way that will mean the most to her. Every word listed is defined and there are no cross-references. Pronunciation is given for each syllable of the word defined. Consider how frequently *you* want to look up an unfamiliar word in the dictionary and you'll realize how welcome this gift will be.

By ALICE L. PRICE, B.S., R.N., Instructor of Nursing Arts at Columbia Hospital, Milwaukee, Wisconsin. 656 pages. Thumb-indexed. $3.75

Morris' Public Health Nursing in Syphilis and Gonorrhea

The public health nurse who has for years been futilely searching for usable information on the problems of venereal disease—will find the answers to her questions right here—in this one book written especially for her. The author covers diagnosis and treatment of syphilis and gonorrhea, epidemiology, available clinic services, the work of agencies and the nurse's responsibility in family education. The nurse will gain an understanding of both the medical and social problems involved, and know how and what to do when faced with them.

By EVANGELINE HALL MORRIS, Associate Professor of Nursing, Simmons College. 239 pages, illustrated. $2.75

W. B. Saunders COMPANY

West Washington Square Philadelphia 5

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

ADVISORY COUNCIL

BOARD OF DIRECTORS

*Member of the Executive Committee

MAGAZINE COMMITTEE

STAFF

Anna Fillmore, R.N.—General Director
Ruth Fisher, R.N.—Associate Director
Lillian Christensen—Assistant Director
Hedwig Cohen, R.N.—Assistant Director
M. Olwen Davies, R.N.—Assistant Director
Helen Nelson—Assistant Director
Dorothy Rusby, R.N.—Assistant Director
Marie Swanson, R.N.—Assistant Director
Elizabeth C. Stobo, R.N.—Director of Cost Study
Dorothy E. Wiesner—Statistician
Mary E. Shaw—Editor

Services conducted jointly with other organizations:
Joint Orthopedic Nursing Advisory Service—Louise M. Suchomel, R.N., Lucy E. Blair, R.N., and Marion P. Kerr, R.N.
Joint Tuberculosis Nursing Advisory Service—Jean South, R.N.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $5; General, $5; Sustaining, $10; Life, $100. Agency—Full dues 1% of annual expenditures for public health nursing service. Associate agency, $10.

HOPKINS
NOPHN
STYLE
UNIFORMS

THE

BERET

Smartly styled to tilt at any angle. In small, medium or large head sizes. Your choice of fabric—

Navy Blue Elastique.....$4.50
Navy Blue Whipcord.....$4.50
Blue and white striped Seersucker....$2.25

THE

OVERSEAS CAP

The universally popular Public Health Nurses cap. Head conforming. Small, medium or large.

Your choice of fabric—
Navy Blue Elastique.....$3.50
Navy Blue Whipcord.....$3.50
Blue and white striped Seersucker....$1.75

THE

NAVY SWEATER

Lovely, soft sweater of 100% pure Australian Zephyr wool. (Sanforlan Shrink proof). It is beautifully hand fashioned and hand finished with Nylon ribbon trim and ocean pearl buttons. Sizes 34 thru 44.

$7.95

HOPKINS TAILORING CO. 107 W. FAYETTE ST., BALTIMORE 1, MD.

What do you demand in a toxoid, Doctor?

small dosage volume?

purity?

concentrated potency?

high antigenicity?

Of course, doctor, you want the best possible combination of these advantages.

Research and manufacturing know-how of CUTTER, first producer of combined toxoids, have developed in their *new* purified toxoids products which meet all of your demands.

As an example, consider the superiority of the *new*, purified **DIP-PERT-TET***—for simultaneous immunization against diphtheria, pertussis, and tetanus:

1. **Immunization routine** *is simplified with three injections of 0.5cc each at monthly intervals.*

2. **Purified toxoids** *assure virtual freedom from reactions due to bacterial protein components.*

3. **Alhydrox****—*CUTTER'S exclusive adsorbing agent—results in a more solid immunity, fewer post-injection reactions, and less pain on injection.*

When single immunizations are indicated or booster shots are required, there is a PURIFIED TOXOID—CUTTER—available in both single and multiple dose packages. Your pharmacist has them in stock.

***DIP-PERT-TET**—*Cutter's diphtheria and tetanus toxoids and pertussis vaccine combined for simultaneous immunization against diphtheria, pertussis, and tetanus.*

****Alhydrox**—*Trade name for aluminum alhydrox adsorption, exclusive with CUTTER.*

CUTTER

CUTTER LABORATORIES • BERKELEY, CALIFORNIA

Christmas Eve (wood engraving) by August von Kreling.
—Courtesy of The Metropolitan Museum of Art.

CHRISTMAS — 1949

PEACE ON EARTH is the hope in the hearts of all this Christmas. Every avenue leading to that end is being anxiously studied. Peace is achieved on local, state, and national levels in the United States, because of government. The hope for peace, world peace, begins to have a measure of reality when we know that our legislators in Washington are seriously, actively, working for peace. It is heartening to see that our Government is not entirely concerned with spending money on materials for war, necessary as they are. This Fall over a hundred legislators signed a resolution—"to support and strengthen the United Nations and to seek its development into a world federation open to all nations—

to preserve peace and prevent aggression."

When world government is established which can maintain peace in the world we will still have need of working for peace in our own small worlds. The nurse brings peace by her presence to individuals and families. It is a plus service above her professional contribution to the community. She is the apotheosis of order and peace. The families she visits are glad to accept her professional knowledge, to follow her leadership as a nurse, that health, peace and tranquillity may prevail.

In the health field we have long ago become accustomed to yielding certain controls to government. It does not conflict with our democratic way of life. In fact it is an expression of that very philosophy. Enough control by a world federation to maintain world peace would in the same way be completely democratic. If it sounds Utopian we can remember that all the great reforms in history have seemed remote and Utopian to most people until they have been accomplished.

Mr. Nehru's theme while speaking in this country has been, "We can prevent war by working for peace." I think we can adopt that as our own and in 1950 work for peace in individual hearts, in towns, in cities, in our country. Through world government, let us work for peace for all men.

MRS. CARL B. GRAWN
SECOND VICE PRESIDENT
NATIONAL ORGANIZATION FOR
PUBLIC HEALTH NURSING

ALLIES AGAINST TB

TUBERCULOSIS is one of the gravest health problems facing the American people today. It is important because in the productive young age group from 15 to 34 it costs more lives than any other disease.

It is important because it is a communicable disease which is killing nearly 1,000 Americans a week.

It is important because 500,000 people are estimated to have tuberculosis, one half of them unknown to health authorities.

Tuberculosis is an important public health problem because *it can be prevented.*

When we know that a disease as costly in lives and happiness can be prevented, it is only common sense for us to spare no effort to root it out of our communities.

The national program of education, case finding, rehabilitation, medical research, under the leadership of the National Tuberculosis Association, is bringing tuberculosis under control in this country. In this program the public health nurse has perhaps the first opportunity on the tuberculosis team to recognize and understand the patient's problems.

You and I can help bring complete victory against tuberculosis. We can become allies in this important battle by our generous purchase of Christmas Seals.

SPEARHEAD OF PUBLIC HEALTH

THOMAS PARRAN, M.D.

As I WAS flying over the Andes last Thursday on my way home from Lima, Peru, I thrust into a back compartment of my mind the health problems of the Western Hemisphere with which we had been wrestling for the past week and tried to think some profound thoughts appropiate to express in New Haven, Connecticut, this evening. For I was genuinely pleased to have the privilege of coming here on this occasion of honor to Miss Fox and the nursing organization which has grown great under her guidance. And I was genuinely apprehensive lest I might fail to find the ultimate word delivered with the spontaneous orginality appropriate at this time.

After consideration, however, it seemed clear that I was taking myself much too seriously. You of New Haven long have been exposed to the influence of this great lady of public health nursing, Elizabeth Fox. You long have been held in thrall by the eloquence of the great philosopher of public health and prophet of its practice—Doctor C.-E. A. Winslow. Who am I to think I might bring you any new thing—any ultimate word on the practical or philosophical aspects of public health? Here you have developed it into a fine art, as against the hacking away at the underbrush which many still must do on its frontiers.

Dr. Parran, dean of the Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania, delivered this talk at the dinner honoring Elizabeth Fox, in New Haven, Connecticut, October 19, 1949. Miss Fox recently retired as director of the Visiting Nurse Association of New Haven.

What I can and shall do, with your permission, is to suggest some of the ways in which you can help those of us on the frontiers. Perhaps they are less far away than you think, certainly not so far as the Andes. We need your help, not necessarily on the obvious sectors of how does one persuade a community to invest more money in its public health effort. Or how does one get more and better trained personnel? Or how does one get community, state and national leadership for public health, yet avoid the barbed wire entanglements of partisan politics? What I have in mind are some of the nuances not often considered, yet rich in their implications in developing citizen awareness and citizen support. Regardless of money or professional staff such support makes the final difference between effectiveness or failure in any public health venture be it official or voluntary.

As I look back over thirty years' work—hard years but not dull—I can see that I have been one of the most fortunate of men in my professional experience. Very early in my career I came under the influence of a wise, highly competent, charmingly and ruthlessly determined public health nurse. It was beaten into my thick young skull then, and I have never forgotten the basic truth of it, that nursing is the spearhead of public health. Without nurses—good nurses, well trained, devoted, determined—the greatest discoveries in preventive medicine remain theory; the most significant advances in environmental sanitation remain unappreciated.

I repeat, I consider myself fortunate to have learned this fact early. I have been

even more fortunate in that from the early 1920's when I helped set up the first rural health nursing service in Missouri, through following years of work in the field fighting preventable disease in fourteen other states, always there was some nurse at my right hand to teach me how to put medical science to work. When in 1930 the U. S. Public Health Service loaned me to New York State, as Commissioner of Health, there was Marion Sheahan. Of all the red-headed women whom I have known and admired, she was the one put into this world to bring peace and not the sword. Quietly, cheerfully she stood at my right hand helping me try to make public health practical.

When I went back to the Public Health Service in Washington in 1936, I had been out in the field so long that I had forgotten how much that organization still was pervaded by what one of my nurse friends calls the "man-woman, husband-wife, doctor-nurse relationship," in which the omniscient male makes both major and minor decisions. Nevertheless, when war came, at least half the headaches inherent in the operation of the huge Cadet Nurse Corps were mitigated by the fact that the size and urgency of the war nursing problem enlisted the services of such distinguished nurses as Lucile Petry and Margaret Arnstein. Now, I am proud to say, Miss Petry is the first woman in this country to become a General Officer—an Assistant Surgeon General.

In other words, the world "do move." It may not be in my lifetime, but conceivably my medical student son may see a nurse as Surgeon General.

What I am saying colloquially is that in the nineteen years since you, Miss Fox, came to New Haven and I went up to Albany on my first major job, we and our colleagues have seen a broadening and strengthening of the whole public health structure and its profit to human life. To achieve this, nurses have toiled through the heat of the day and have borne the brunt of the battle. Slowly and as yet partially, doctors, engineers, dentists and others trained in the various disciplines which make up the public health composite are beginning to be aware that the nurse is the spearhead. New Haven has contributed greatly to acceptance of the concept that she is an equal partner in a balanced health team.

UNFORTUNATELY, however, we are desperately short of nurses; short of all kinds of nurses but most particularly of public health nurses—educated women who can become high-level educators; women with the capacity for leadership. Never, in my opinion, has the nursing profession or the field of public health practice needed leaders so much.

Yet you and I know a number of families where favorite daughters were dissuaded from nursing as a vocation. Undoubtedly you all have heard the story of the fond mother who complained to her friends that her daughter was just too stubborn. She was determined to be a nurse and there was nothing the parents could do about it. But the mother brightened up somewhat as she came to the end of her recital. "At least," she said, "we have gotten her in at Yale. They tell me that there nurses are quite socially acceptable!"

Silly though the tale is, it has a certain wry authenticity. Perhaps not the least of your contributions here may lie in that fact. To put it more gracefully, you honor nursing.

I think you will agree that there is a common denominator among American families: parents everywhere in this country of ours want their children to have more opportunities than they did, to be more successful and to have an easier road to follow. It is that last implication, I believe, which keeps many young women out of nursing. No one can truthfully say that the way of the nurse is an easy one, especially that of the nurse leader. Consequently, good citizens who have come to appreciate the value of nursing to a community must give it more than lip-service or financial support. We can not get the best out of it unless we put our best into it, in terms of our best young minds—the daughters with vigor, imagination and zeal for human service.

In order to achieve this I am not proposing that we propagandize illusions as to the ease of the task or the emoluments of the nursing profession. No art, craft, science, or profession may be mastered without drudgery. Many repay mastery with more money, with swifter

recognition and with more personal rewards. Nevertheless, those of us who want the most for our children in life, want deep down to make sure that at the end of life they will have found it worth living. Science is our twentieth-century god. In my experience, it is the nurse who humanizes medical science. She deals with life. If the spark of intellectual illumination is in her, she comes earlier than most of us to an understanding of life, which is its greatest reward and final security.

I have been talking about nurses in general and about public health nurses in particular. Both are of many kinds and categories. All are useful. With certain exceptions—of which you, Miss Fox, are a distinguished example—few have explored fully their potentialities in a community. In fact, among the many reasons why I am happy to be here tonight is that I am proud to be among those paying tribute to the nurses who serve the voluntary agencies.

I have had long and happy contact with the voluntary health and welfare agencies which frequently blazed the trail later to be followed by public officials.

We are a nation becoming increasingly industrialized, urbanized, interdependent. With every new discovery in the health sciences there has come a multiplication of the things we can do to save life, to prevent disease and disablement, to rehabilitate the handicapped. With the broadening of the base of needed action, it is inevitable that the public interest should take up the load at the point where private philanthropy can carry it no further. Or, as so often happens, when the voluntary agency has demonstrated a technic among a limited number of beneficiaries, the taxpayer's money can carry forward the work for the entire population.

I have no patience with those who now or later would omit the voluntary agency from our programs for health. There are still so many trails to blaze through pioneer country. There are still so many frontiers of health, unmapped and unexplored, which will need the flexibility, the freedom to experiment, the ingenuity which has been characteristic of volunteer agencies all over the country.

For example, science has been working on the degenerative problems of old age. As the laborers in that field come up with more basic knowledge, the visiting nurse will be among those who will effect its practical application to human needs. We have barely scratched the surface of what can be done in the rehabilitation not only of the crippled but of the chronically ill and arrested cases. Much can be done to restore the self-sufficiency of the now helpless aged. Too much, in my opinion, of the services for the blind and the deaf are institutionalized. Many of the mentally ill, under sound psychiatric supervision, would be happier and better cared for in their own homes if a psychiatric visiting nurse were at hand to smooth out the rough places and teach the family how to care for its own.

In all likelihood, such a broadened service would require public funds supplementing the budget of a visiting nurse association. There is reason to believe that the taxpayer would benefit: first because of the high cost of institutional care; second, because of the greater benefit to all patients not acutely ill and the better education of the families involved; third, and not least, because this policy or any adaptation of it would preserve the flexibility and individual approach of the voluntary agency, while recognizing the cooperative responsibility of the community as a whole.

I am not recommending this as a concrete project to any visiting nurse association. In mountain country it is said that only fools and newcomers try to prophesy the weather. I have not that temerity. What I am trying to say is that the only guidepost you need is one on which the sign says "Future Unlimited."

Set aside, as promptly as you may for other hands to do, the technics thoroughly demonstrated and the work become routine. Plunge into the unknown, the untried, the badly needed experiments of what kind and type you choose as opportunity presents itself.

Many have told me that yours is a model visiting nurse association. I know that your relations with the City Health Department are close, each supplementing the other, with no voids in service. I know that your fine hos-

pitals in New Haven and the Yale School of Nursing feel themselves fortunate to be able to utilize your field training facilities. I know that when foreign nurses come to this country to visit and to learn, yours is one of the first agencies to which they are sent. We always hope they will think that you are typical of visiting nurse work throughout the country.

Unfortunately, you are not typical, which lays a great, and perhaps unfair, responsibility upon you. You have been more than generous of your time and effort for those who visit and learn. Might it be possible for you to be even more evangelistic? Might your association, and others in your top bracket, add training for the hinterlands to your daily task? Even one or two young women a year, with the proper educational background, trained here for the enrichment of nursing in our less fortunate communities—our frontiers—could contribute much to good nursing as a national factor in public health.

THERE IS MUCH tumult nowadays about the future of medicine and of public health. As for myself, I look at the present with serenity and at the future with hope. In both medical practice and public health programs there are as many imperfections as we find in commerce, industry, and diplomacy, nationally and internationally. But as I look back over thirty years it is heartening to see how rapid has been the movement forward and how sharply the trend is up.

In our country, the epidemic diseases of bacterial origin have been almost conquered. The scientific base from which we proceed to the conquest of the viruses, cancer, the degenerative diseases, and other serious enemies of mankind has become infinitely broader and more solid. No Pasteur for mental disease has as yet emerged, but fine minds are working at this problem.

A vast amount of research is necessary. Much is under way. One cheering characteristic of medicine in 1949, in contrast to earlier generations, is that we know what we do not know. As regards the degenerative diseases alone, of special significance to a country with an aging population, there are literally thousands of questions to which we do not know the answers. These questions relate not only to pathology in the individual but to environmental influences. Why, for example, does a report from Great Britain indicate that the death rate from coronary disease is twelve times as high among doctors as among agricultural workers? Why, also, is the death rate from coronary disease among bankers and businessmen only half that of doctors, though higher than that in the general population? Add to this complex situation the problems in regard to such disabling diseases as arthritis and rheumatism. Consider the economic as well as the human problems in our already enormous but still rapidly expanding mental hospital population. You will see that each of us has not only a personal but a business stake in the effort to control mankind's contemporary afflictions, now that some of the ancient scourges are behind us. You may be sure something will be done about it. You may be sure the nurse will be the spearhead in applying new knowledge.

As we read American history we find that real progress has been made swiftly against any situation which touched both our hearts and our pocketbooks. The American temperament, at its best, appears to be a happy mixture of business shrewdness and generous compassion.

For the future I think it inevitable that medical care programs will be greatly broadened and the cost distributed either through taxes or insurance or both. I think it imperative that in any system of medical care official and voluntary services continue to do the kind of teamwork which you have demonstrated. Unlike many of my medical friends, I do not lie awake nights worrying about whether insurance payments will be voluntary or compulsory—although like everybody else I do worry occasionally about taxes. I think I would worry less about taxes if more of them were going for hospitals, for health science and research, for the training of doctors, nurses, and other life-savers. Also, I wish that a larger part of the tax dollar might go into public housing and better schools—into all of the works and services which conserve and upbuild our human resources.

I am inclined to agree with Richard Living-

stone, who says that the complaint he makes about those who wish to base education exclusively upon the sciences is that they are aware of some of the needs of our time but not of its greatest need. He goes on to philosophize on the subject of education which has many tasks—training the mind and enlarging its interests, teaching the technics on which modern civilization is based. But, he contends, it may do all this and never reach our central problem.

WHAT RAISES man above the savage? His inventions, his science, the work of his doctors, his engineers and his chemists? We have only to consider recent history to see that these things do not necessarily civilize man. If economics, science, technology, and organization were all that were needed, there was nothing wrong with Nazi Germany.

It is not our material civilization that is defective; it is ourselves. The real issue is whether men are to be ruled by power, pleasure, the latest bright toy they have invented, or by goodness, beauty, reason, compassion.

The more power science puts into our hands, the greater the opportunities for evil as well as good. A poor man, a poor world, are limited by their poverty in the amount of harm they can do. As their wealth increases, their power to do harm increases.

We live in a world where the power of our country gives us the chance of doing unlimited good or unlimited harm. We need an education which teaches us not only how to use power but how to use it well. To build up in every man and woman a solid core, really and fully human, which will resist the attrition of everyday existence in our mechanized, industrialized world—that is the most difficult and important task of any science and any profession.

You must forgive my going off at this tangent. It provided the background for my statement of a few minutes ago that nursing humanizes medical science as well as performs the practical services essential to its application. Great nurse leaders have been more than teachers and organizers. They have had that rare power of instilling goodness, reason, compassion. They have been able to see the beauty of life and to fight for it against all odds. They have contributed equally with the scientists to the movement forward and the upward trend of public health. Because of them, thousands now live who otherwise would have died; thousands have been relieved of suffering; thousands have taken courage from their strength.

Within another ten years, Miss Fox, I shall be entering, I hope, into my own retirement from routine tasks. I hope that as in your case, it will leave my mind and my heart free for the essentials of living and the part that our professions play in it. I trust that your profession and mine, so closely inter-related in the march of public health, may long have the benefit of your counsel and reap from your advice the fruits of your rich experience.

The British have a custom that I like. Upon women of distinction, whose life and work have enriched contemporary humankind, they bestow the title, Dame of the British Empire.

I think in your case, Miss Fox, one would be tempted to offer a variety of titles: Countess of New Haven, Duchess of Connecticut, Dame of the American Republic. Please take your choice.

CHRISTMAS GIFTS

ELIZABETH REED, R.N.

IT WAS the morning of December 22. Jane Randolph, a staff nurse in the Central City Visiting Nurse Association, picked up her bag, ready to go to work for the day. She was tired and disgusted. Tired—from Christmas shopping and her heavy case load; disgusted—she was about to lose her wonderful little efficiency apartment, because the landlady had raised the rent; the brakes on her car were bad again; she needed a new car but couldn't afford one; and worst of all, the promised raise hadn't come through, for the Community Chest had not reached its goal during this campaign. She was sure that Miss Green, her supervisor, didn't understand her; that she, herself, would never be anything but a staff nurse. And she had "had words" with her best friend on the staff, all over the ownership of a 2 cc. syringe.

It was a slushy day underfoot, and Jane had difficulty in getting her car to start. Christmas decorations were everywhere and happy harassed shoppers bent their heads to the wind. The first person to be seen was old Mrs. Stevens. She had a colostomy and cared for it poorly. She was now confined to her bed most of the time and was losing ground daily. Her husband was a wizened little man who stayed in a semi-drunken condition. The house was dirty and cold and the dressing and bath were accomplished under difficult conditions. As Jane repacked her bag and prepared to go, Mrs. Stevens fumbled under her pillow and brought out a package wrapped in wrinkled tissue paper. Pushing her wispy grey hair back from her bony face, she propped herself up on one arm and held out the package to Jane. "Here's a little Christmas remembrance for you," she said. "I done it myself, when I had the strength. You been good to me." Jane unwrapped the gift—a small lop-sided crocheted doily, slightly grimy from these weak and feeble hands. She thanked Mrs. Stevens warmly and went out into the cold again—a glow inside her.

Jane's next stop was at Mrs. Guy's. There was a return demonstration of a baby bath to watch today. Mrs. Guy had had a very difficult pregnancy and Jane had made many visits to this neat little apartment. Mrs. Guy was young, enthusiastic, and did a creditable job of bathing her first born. As Jane turned to go and said, "I hope you all have a very pleasant Christmas," Mrs. Guy impulsively clutched her by the arm.

"I do so wish I could have given you a Christmas gift. But you know how it is—we're just broke. And if it weren't for you, I don't think I would have had the baby. Thanks for everything." And with that she suddenly leaned forward and kissed Jane on the cheek. Jane walked to the car on air.

Mr. Cole, Jane's next stop, had a leg ulcer. He kept his small cottage immaculate and was a gruff and gloomy soul. This morning, however, he was talkative. His son was coming to take him home with him for Christmas, "And so you be sure and put a good strong bandage on my leg. It'll have to last three or four days. And, by the way, old friend of mine has an orange grove down in Florida now. Sent me a whole crate of oranges. Really good, too. I've fixed up a

Miss Reed is director of the Division of Health Information, Florida State Board of Health. She was formerly director of the Jacksonville VNA.

sack for you. Thought you'd enjoy them for Christmas. You've been pretty faithful, coming to see a cranky bird like me." Jane clutched the bag of oranges as she climbed back in the car.

Lunch, as usual, was at Henry's Diner. As she sat down, Henry himself walked up to her table. He looked admiringly at Jane's rosy cheeks. "Real Christmas weather, isn't it? Makes you feel good. And Red and me," indicating the short-order cook, "we're happy, too. That was good advice you gave Red about where to take his wife. She's in the sanatorium now, and doctor says she may not have to stay too long. Red's lungs are O.K., too. He went down to that clinic you gave him a card to. So you're having lunch on the house today. Sirloin steak and French fries, and anything else you want. Don't thank us. We're glad to do it. Look what we owe you!"

The first call after lunch was at Mrs. Thomas'. She was pregnant, a dark silent woman in her thirties who had stated briefly when Jane had first called, "I have no husband." Today, she and her sister were seated at a table, making Christmas wreaths. The sister left the room and Jane talked with Mrs. Thomas, asking the routine questions. Finally, Mrs. Thomas suddenly said, "I'm really feeling much better than I did. I only have a month more to go and then it'll be over. I don't know what I'm going to do with the baby, but things'll work out some way. I think I'm going home tomorrow to see my folks—the first time in a year. They say they want me, and you've helped me to feel better about it—to make an 'adjustment'—is that what you call it? When I found out I was pregnant I tried to kill myself. But I feel different now." Jane left her working assiduously at the tying of a big red bow.

A wreath made by an inexperienced hand met Jane at her next call. It adorned the front door. A crudely lettered sign in the center said, "Merry Christmas, everybody." Apparently the Crandalls were away for the holidays for no one answered the bell.

At the next and last stop, Jane had just started to get out of the car, when she saw a small boy with braces and crutches walking awkwardly but capably toward her. "Look, Miss Randolph," cried Tommy Bivens. "I'm walking—all by myself. Don't I do good!" Jane sat back and admired Tommy's erratic footsteps and thanked God that he *was* walking; it had seemed for a time that he wouldn't.

Jane wearily let herself into her apartment. Not really tired—well, not in spirit, anyway. Just a good physical tiredness. She collected the pile of Christmas cards from her mail box, called for her packages from the janitor, and settled herself down to enjoying them. The florist's box was opened first. A dozen American beauty roses! With her mouth hanging open, Jane read the signature on the card: Lucile Walker Andrews. The letter accompanying the flowers, however, was signed by Mrs. Andrews' social secretary, Miss Hilliard. It said, in part, "Mrs. Andrews is most grateful for the care she received from you in her home, during the flu epidemic this past spring. She wishes to send you this small token of her appreciation and wants you to know she is sending a check to forward the work of your organization."

Jane was a methodical person. From her desk she drew a small notebook and under the heading "Gifts Received—Christmas 1949" she listed:

Mrs. Stevens—1 doily
Mrs. Guy—1 kiss
Mr. Cole—6 oranges
Henry—wonderful lunch
Mrs. Thomas—2 lives
Tommy Bivens—2 walking legs
Mrs. Andrews—long-stemmed roses

Drawing a piece of notepaper towards her she began another list:

If I were Santa Claus, I'd bring—
1 bright bedspread for Mrs. Stevens
1 pretty dress for Mrs. Guy
1 happy home for Mrs. Thomas

. . . the pencil stopped. How good it is to be alive this Christmas season! What wonderful gifts she had received! Jane's head went down on the desk. Her full and overflowing work day had come to an end.

DIETARY SERVICE IN A MATERNITY CLINIC

MIRIAM E. LOWENBERG, PH.D., MILDRED MOUW, R.N.,

AND LAURA WEYRICK, R.N.

"YOU CAN'T build a baby on sweet rolls and coffee." This statement has now been proven through research. The studies of Burke,[1] Balfour,[2] Ebbs,[3] Peoples' League of Health,[4] and numerous other workers regarding the relationship of diet to the health of the pregnant woman and the growing fetus provide evidence that adequate diet is necessary for every pregnant woman.

At the maternity clinic of the Rochester-Olmsted County Health Department all pregnant women have dietary supervision. In preparation for the institution of this dietary service, a preliminary survey was conducted to discover what the pregnant women in Rochester-Olmsted County were eating. The survey was undertaken by the nutritional supervisor of the Rochester Child Health Institute who offers nutrition consultant service to the Rochester-Olmsted County Health Department which operates the maternity clinics.

Women in Rochester and Olmsted County receive their maternity care from one of two sources, either from a maternity clinic or as patients of private physicians. Those who visit the maternity clinics are examined by Fellows of the Mayo Foundation under the supervision of the physicians of the Section of Obstetrics and Gynecology of the Mayo Clinic. Those patients who receive care by physicians of their own choice select a doctor engaged in private practice in Olmsted County or adjacent area or a member of the Section of Obstetrics and Gynecology of the Mayo Clinic.

In order to have a representative study, one half of the group of subjects for the survey were taken from those receiving care in the maternity clinics, and the other half from those receiving care under private physicians. In this case the private physicians were those in the Section of Obstetrics and Gynecology of the Mayo Clinic. Women who need assistance in making plans for their delivery are referred to social service agencies and through them to the maternity clinics.

Diet histories were taken on a total of 162 pregnant women as they made their regular

Dr. Lowenberg is nutritional suupervisor of the Rochester Child Health Institute. Miss Mouw is director of public health nurses and Miss Weyrick, director of the student program, in the Rochester-Olmsted County Health Unit, Rochester, Minnesota.

The Rochester Child Health Institute operates under grants in aid from the Mayo Association, Mead Johnson and Company, United States Public Health Service, The Schlitz Foundation, and The Field Foundation.

TABLE 1. COMPARISON OF DIETARY RATINGS OF GROUPS FROM MATERNITY CLINICS AND PATIENTS OF PRIVATE PHYSICIANS.

	Total number in group	Excellent and good	Fair	Poor
Group I				
Patients of private physicians	27	12	10	5
Patients of Health Dept. Maternity Clinics	27	10	16	1
Group II				
Patients of private physicians	27	17	9	1
Patients of Health Dept. Maternity Clinics	27	16	9	2
Group III				
Patients of private physicians	26	14	10	2
Patients of Health Dept. Maternity Clinics	28	17	9	2
Total	162	86	63	13
Percent	100%	53.0%	38.9%	8.0%

visits to the clinic or to the office of the physician. Thus a random sample of pregnant women in Rochester and Olmsted County was obtained.

Each woman was asked to recall what she had eaten on the previous day. Thus the nutritionist was able to do a comparatively quick survey. Those who are in charge of this service did not want to delay the setting up of a procedure of diet supervision. The survey was expected to yield desirable information on the following points:

1. Inadequacies of specific nutrients in these diets
2. Differences in adequacy of the diets in various socio-economic groups
3. Condition of pregnancy affecting the woman's normal appetite
4. Likes and dislikes that affect food intake
5. Cultural patterns which affect the food habits of women of the community

As an introduction to the taking of a diet history, the nutritionist simply told the woman that she was making a survey of what pregnant women in the area were eating. Each woman was also told that in no way would her diet be singled out for criticism.

The women evidenced little difficulty in recalling, when each meal was discussed separately, what they had eaten on the day previously. An attempt was made to determine as accurately as possible the quantities of foods consumed at meals and in between meals. The establishment of rapport was felt to be of great importance. An evidence of this was the remark by one woman who said, "All right, if you are not going to scold me, I will tell you the truth." Eighty-three percent of the women said the day's food reported was typical of their diet. If the previous day's diet was not typical, the woman was further questioned as to what she usually ate.

Group I, as referred to in the accompanying tables, was composed of those women who had completed the first trimester of pregnancy. Group II was made up of women who had completed the second trimester of pregnancy. Group III was composed of women who were near term. A two weeks' range was allowed.

The diets were graded and rated for adequacy according to the requirements set up by Burke *et al.*[1]

Table 1 indicates that the adequacy of the diets did not vary widely in the two groups. Almost 47 percent of the entire group were taking diets rated below *good*.

TABLE 2. RELATIONSHIP OF DIET RATING TO SOCIO-ECONOMIC GROUP.

	Excellent and good		Fair		Poor	
	No.	Per-cent	No.	Per-cent	No.	Per-cent
Professional and skilled trades	17	42.5	20	50	3	7.5
Farmers	25	67.5	12	32.5	0	0
Semi-skilled trades, work in small businesses and day laborers	47	55.3	28	32.9	10	11.8

In general, the diets of the farm women were more adequate than those of women living in Rochester or small towns in the country. This might be explained in part by the fact that meat was in short supply on the market when this survey was taken and that most of the farm women had their own supply. There were fewer excellent and good diets in the professional and skilled trades groups than in the other two groups. There were, however, more poor diets in the lowest socio-economic group. In other words, the women who had poor diets in the lowest socio-economic group were the ones who probably needed financial assistance.

TABLE 3. RATINGS OF DIETS FOR INDIVIDUAL NUTRIENTS.

	Excellent and good ratings Percent of total group	Fair and poor ratings Percent of total group
Protein	71	29
Calcium	62	38
Iron	64	36
Vitamin A	61	39
Ascorbic Acid	70	30
Thiamin	51	49
Riboflavin	65	35
Niacin	39	61
Vitamin D	26	74

Table 3 shows that 71 percent of the total number had sufficient protein to be rated as excellent and good and 70 percent had sufficient ascorbic acid to be rated as excellent and good. Only 26 percent of the women had a good intake of Vitamin D.

TABLE 4. RELATIONSHIP OF FOOD DISLIKES* TO ADEQUACY OF DIETS.

	Excellent and good diets		Fair and poor diets		Total	
	No.	Percent	No.	Percent	No.	Percent
Number of women with food dislikes	7	25	21	75	28	100
Number of women with no food dislikes	82	61.2	52	38.8	134	100

*Dislike of such foods as milk, eggs, and necessary vegetables. If, however, a woman disliked fish but not meat or disliked only one or two vegetables or fruits, she was not rated as disliking a necessary food.

Table 4 shows that 75 percent of the women with definite food dislikes had fair and poor diets. However, 38.8 percent of the women who had no dislikes had fair and poor diets.

TABLE 5. EFFECT OF PREGNANCY ON THE NORMAL APPETITE.

	Increase in appetite		Decrease in appetite		No change in appetite	
	No.	Percent	No.	Percent	No.	Percent
Group I	21	38.9	12	22.2	21	38.9
Group II	25	46.3	9	16.7	20	37.0
Group III	25	46.3	11	20.4	18	33.3
Total group	71	43.7	32	19.9	59	36.4

Table 5 shows that a somewhat higher percentage of women had an increase in appetite during the second and third trimester of pregnancy than during the first trimester. Of the women who had a change in appetite during the second and third trimester of pregnancy, somewhat more than twice as many reported an increase as reported a decrease in appetite.

This survey pointed out that the pregnant women needed more adequate instruction in diet. The Health Department believed that a plan to meet the need could be worked out.

Beginning January 1, 1946, the services of the nutritionist of the Rochester Child Health Institute were available to the Health Department. Since her work included many other types of community nutrition she could not do the job alone. Student dietitians from a local hospital training course had been assigned regularly for several years for a two-weeks period of observation and assistance in these clinics. These dietitians did not know the families nor could they supervise the woman throughout her pregnancy.

Public health nurses with their knowledge of families and their background of training can do an excellent job of diet instruction in a maternity clinic. Through in-service training with a nutritionist their knowledge of nutrition can be enriched. A plan for using the public health nurses and the student dietitians in teams was worked out. The supervising nurse and the nutritionist set up such a plan.

Food	Size of serving	Servings	Calories	Units							
				Protein	Calcium	Iron	Vitamin A	Ascorbic acid	Thiamin	Riboflavin	Niacin
PROTEINS											
Milk											
Whole	1 measuring cup or 8 oz.	1	160	85	28	5	410	2	10	43	3
		2	320	170	56	10	820	4	20	86	6
		3	480	255	84	15	1,230	6	30	129	9
		4	640	340	112	20	1,640	8	40	172	12
Skimmed	1 cup or 8 oz.	1	90	85	29	7	25	2	11	43	2
		2	180	170	58	14	50	4	22	86	4
		3	270	255	87	21	75	6	33	129	6
		4	360	340	116	28	100	8	44	172	8
Meat											
Veal, beef, fowl, lamb	1 medium serving (5-6 servings per lb.)	1	160	180	1	31	20	....	9	15	39
		2	320	360	2	62	40	....	18	30	78
Liver	1 small serving (7 servings per lb.)	1	80	120	1	49	16,500	9	12	122	60
		2	160	240	2	98	33,000	18	24	244	120
Pork	1 medium serving (5-6 servings per lb.)	1	205	180	1	24	.....	....	60	15	32
		2	410	360	2	48	.....	....	120	30	64
Luncheon meat (cooked)	2 slices minced ham or luncheon meat or ½ frankfurter	1	80	50	....	7	.....	....	9	7	8
		2	160	100	....	14	.....	....	18	14	16
		3	240	150	....	21	.....	....	27	21	24
		4	320	200	....	28	.....	....	36	28	32

A sample page from "Score Your Diet"

A public health nurse is assigned to the diet service of the maternity clinic for a period of two months. She is the leader of the diet team who gives the instructions.

As a nurse comes new to this service she observes both the nutritionist and the supervising nurse at different times giving the instructions to the patient. She also familiarizes herself with food values, and types of diets to suit individual needs. As the nurse herself feels that she is ready, she takes over the job of interviewing patients. Each year the nursing staff has requested the nutritionist to conduct approximately eight discussions on the general subject of nutrition. Nurses also have frequent scheduled and incidental conferences with the nutritionist.

THE DIET INTERVIEW

Dietary supervision of all pregnant women who are registered in the maternity clinics of the Rochester-Olmsted County Health Department is initiated at the first clinic visit.

Suppose we follow a woman through her first diet interview. When the woman comes to the diet table the nurse and the woman talk together about the need for a good diet during pregnancy for the health of the baby and for the health of the expectant mother. The nurse explains that the expectant mother is building a baby whose physical body will be affected by the kind of building material she furnishes through the food which she eats.

The nurse discovers the woman's level of understanding of diet and nutrition through conversation with her. She tries to gain some insight into the family's income, to uncover the woman's food likes and dislikes, to discover how cultural patterns affect her food habits, and to learn if hunger is a problem during her pregnancy.

The diet team tries to reconstruct what the woman ate on the previous day and the nurse writes down the amounts of food as accurately as possible. The dietition takes this day's diet and proceeds to compute it. A device "Score Your Diet"[5] designed for a rapid computation of a diet is used. (See illustration above.) The food values in the "Score Your Diet" are expressed in units to prevent having to explain the terms milligrams, grams, et cetera. A line is drawn under the number of

portions of each food eaten. The values for each nutrient are then totaled.

While the dietitian is scoring the diet, the nurse and the woman discuss the pamphlet "Building Your Baby"[6] which has been written for this specific purpose. They go over it together and the nurse points out why each item in the diet is necessary. The woman may express certain dislikes for foods such as milk. The nurse suggests ways of using milk in cooking or of adding flavorings to make it acceptable, or of putting dried milk powder into her food.

The survey revealed that only 26 percent of the pregnant women in Rochester and Olmsted County were taking the recommended daily allowances for Vitamin D. The woman and the nurse note that the amount and kinds of food usually eaten will not meet this recommended allowance and that a vitamin supplement will be necessary.

After the diet is scored the woman, the dietitian, and the nurse look over the values for each nutrient to see how they compare with the recommended daily allowances. Suppose the woman had taken 650 units of protein and 850 units (85 grams) is the recommended daily allowance. They go back to review the protein-high foods in "Score Your Diet" and discover that by using two extra cups of milk and a larger serving of meat the protein requirement would have been adequately met. This method helps the woman to see how she can build up her own diet to bring it to adequacy. She is given her "Score Your Diet" if she wishes it to help her in making choices of foods. Some women are interested in scoring their own diets at home and many bring a few days' computations with them on their next clinic visit and ask specific questions about them.

The following are samples of data obtained from diet interviews in the maternity clinics. These data are kept on a card for each expectant mother:

CASE 1

Expected date of confinement 2-2-48.

10-17-47—Diet calculated. Low in eggs, fruits, vegetables and milk. Will try to flavor milk and increase amount in cooking. Suggested vitamin supplement. Given "Building Your Baby." See next visit regarding adequacy of diet.

11-14-47—Gained 4 pounds.

12-12-47—Diet appears to be more adequate in milk, fruits and eggs. Not taking vitamin supplement. In view of weight gain suggested fruit for desserts, skim milk, and no fried foods. Check weight next time.

12-31-47—Lost 1½ pounds.

1-9-48—Taking vitamin supplement. Gained 1 pound. Check weight next visit.

1-23-48—Gained 4 pounds. Is drinking a quart of milk and taking vitamin supplement daily. Weight gain probably due to eating between meals. Check next visit.

1-28-48—Gained only ½ pound. Total gain about 15 pounds.

CASE 2

Expected date of confinement 3-31-48.

8-22-47—Patient is nauseated. Not eating much. Discussed foods to eat now. Did not do diet computation because of vomiting. Likes all foods. Previous daily diet good. Seems intelligent and very interested. Gave "Building Your Baby."

10-17-47—Diet calculated. Low in vegetables, fruits and eggs. Watching weight gain herself. Seems interested.

11-14-47—Eating more vegetables and eggs. Still some nausea. Discouraged sweets and fried foods.

1-9-48—Has gained 5 pounds. Suggested omit salad dressing and fried foods. Patient asked about bananas. Eats 2-3-4 daily. Suggested substituting other fruits. Patient asked about unsweetened pineapple juice. Suggested canned orange and grapefruit juice because of high Vitamin C content. Interested and asked many questions.

1-23-48—Gained 3½ pounds since last visit. Eager to know ways of cutting down. Doesn't eat bananas, drinks skim milk. Check weight next visit.

2-6-48—Reviewed ways of cutting calories.

3-5-48—Gained 5 pounds. Reviewed foods high in calories that could be avoided. Given "Score Your Diet" to use.

3-10-48—Lost 2¼ pounds.

3-17-48—Gained 3¾ pounds in one week. Has had rich desserts "a few times." Advised to omit all desserts except the fruits suggested in a previous interview.

CASE 3

Expected date of confinement 6-3-48.

1-28-48—Diet calculated. Adequate in nutrients except Vitamin A and thiamin. Likes milk and will drink 1 quart daily. See next visit.

2-27-48—Gained 6 pounds. Suggested including more vegetables high in Vitamin A, skimming milk, avoiding gravies and fried foods, eating smaller servings of cereal and substituting fruit for rich desserts. Given "Score Your Diet."

3-26-48—Gained 4 pounds. Is taking 1 quart of skim milk a day. Eats a great deal of cake and rich desserts. Is taking a vitamin supplement each day.

4-23-48—Is cutting down on starchy foods. Lost ¾ pound.

6-11-48—Gained 25 pounds to date. Has cut milk intake somewhat due to hot weather. Advised to drink fruit juice instead of soft drinks and to get full quart of milk.

CASE 4

Expected date of confinement 3-1-49.

7-9-48—Diet calculated. Low in calcium, thiamin and riboflavin. Instructed in 1200 calorie diet as patient feels uncomfortable because of weight gain. She eats large servings and much starchy foods. Gain in weight to date is 18 pounds. Does not like green leafy vegetables. Given "Score Your Diet" and "Building Your Baby."

10-6-48—Missed appointment.

1-19-49—To date has gained 38½ pounds. Has not followed 1200 calorie diet. Eats much butter, bread and fries most of her foods. Has had a craving for sweets. Suggested avoiding fried foods, limiting bread and butter and omitting sweets. Suggested apples, oranges, carrots or celery between meals. Believe patient has no intention of trying to lose weight. She knows what to limit, but does not have "will-power" and is "lonesome here."

CASE 5

Expected date of confinement 8-29-48.

3-26-48—Diet calculated. Low in most food nutrients. Suggested 1 qt. of milk a day and 2 servings of citrus fruits a day. She said she would do so. "Score Your Diet" given and patient will return with diet calculated. "Building Your Baby" given. Vitamin supplement advised.

4-23-48—Has not been taking vitamin supplement, but was advised to do so. Has been following a good diet and scored three days' intake for herself. Was low in iron and Vitamin A. Plans to take liver more often. She is drinking one quart of milk daily.

6-25-48—Weight gain ¼ pound a week. Total weight gain 19¼ pounds. Is doing well in getting a good diet. Recipes given.

SUMMARY

The public health nurse recognizes that the two months as diet nurse are a very valuable experience. She learns that handing out a diet list and expecting the woman to solve all her dietary problems in no way guarantees that she will take an adequate diet. She learns rather that only in so far as the woman can be motivated to help herself to improve her diet will there be changes. The public health nurse learns practical nutrition which she can use in her daily contacts with families.

The guidance given the woman at the diet table not only has an educational function which may carry over into the job of feeding her family, but it has a therapeutic function as well. The public health nurses giving diet supervision have realized that emotional tensions enter into the problem of diet. Sympathetic understanding, support, and encouragement often are necessary before the expectant mother will be motivated to eat a good diet and to take the responsibility for building her baby.

REFERENCES

[1]Burke, B. S., et al. The influence of nutrition during pregnancy upon the condition of the infant at birth. *Journal of Nutrition*, December 1943, v. 26, p. 569-583.

[2]Balfour, M. I. Supplementary feeding in pregnancy. *The Lancet*, February 12, 1944, v. 246, p. 208-211.

[3]Ebbs, J. H., Tisdall, F. F., and Scott, W. A. Influence of prenatal diet on mother and child. *Journal of Nutrition*, November 1941, v. 22, p. 515-526.

[4]Nutrition of expectant and nursing mothers. Interim Report of the People's League of Health. *The Lancet*, July 4, 1942, v. 243, p. 10-12.

[5]Lowenberg, Miriam E., Mouw, Mildred, Nyhus, Dolores, and Weyrick, Laura. Score your diet. Rochester Child Health Institute, 1947. Revised 1949. Whiting Press, Rochester, Minn. 25 cents a copy; 20 cents for 10 or more.

[6]Building your baby. Rochester Child Health Institute, 1947. Whiting Press, Rochester, Minn. 20 cents per copy; 16 cents in quantity lots of 10 or more.

GLORY AT SANDY SPRINGS

EUNICE R. LAMBERT

LOOKING AT the really excellent facilities of the Sandy Springs Health Center today—its splendid coordinated nursing and medical services, its active and enthusiastic Lay Committee continuously on the alert to better these facilities and to cooperate more and more fully with the medical and nursing staff in order that the greatest possible number of people can be served in the best possible way—looking at Sandy Springs, a county that has just begun to plan for a health center might almost despair. They think "Sandy Springs—Fulton County—Georgia—rich northwest section—of course they could do it, but we are a sparsely settled community with little money, no adequate building—we haven't this and we haven't that." It's true there is wealth in Fulton County but there is also an unbelievable amount of poverty and distress—certainly very much more (and in many instances the need is more acute) than in your less thickly populated community. It is also probably true that for every drive for funds, for every hour asked for volunteer social sevice in your community, there are probably ten asked for in Fulton County. There are literally hundreds of activities to interest and attract in a closely populated area making it therefore more difficult to line up a community solidly behind any single project.

Mrs. Lambert is a citizen of Sandy Springs, profoundly interested in public health nursing, and active in the Lay Committee of the Health Center.

But to get back to the Sandy Springs Health Center—its birth and development. There was a time (and not so very long ago) when all Sandy Springs had was a tremendous need and, I believe we might add, a particularly social-minded postmaster and his wife. There was a ruling in Fulton County at that time that if someone required free medical service at Grady Hospital in Atlanta, he must present a letter from his postmaster stamped with his official seal in order to be admitted to a clinic. So day after day Mr. Adolphus was called on to write and place his official seal on these letters, but unfortunately that wasn't all. It so happened that often the sick person had no transportation, was so destitute that he had no money to secure transportation and no possible way of getting to Grady with his letter from Mr. Adolphus. So there was nothing for the good postmaster to do but load the sick in his car and take them in to Grady. But Mr. Adolphus wasn't very strong himself. He had had to give up his chosen profession because of his health. And Sandy Springs was a small post office, at the time, with a very small salary which limited what he could afford to do, no matter how kind and generous his heart. So Mr. and Mrs. Adolphus began talking to their friends, neighbors, and members of the Sandy Springs Civic Club about the need for a health center right there in their own community.

When Dr. Roy McGee, county health commissioner, was approached on the subject, he

explained that before the county could establish a center, it would be necessary for the community to take certain initial steps, chief of which was to secure an adequate building. It was Mrs. Carl Heard, I've been told, who told Mrs. Adolphus one day that she was pretty sure Dr. Griffith would let them have that old empty building between the drugstore and the filling station. Dr. Griffith said, "Why yes"—it was empty and not doing him any good, but it was powerfully dirty and he wouldn't doubt they'd have to do a little repairing but if they wanted it as it was, they were welcome to it.

Dirty it was all right, the ladies found after scrubbing their fingers practically to the bone and it still wouldn't come clean—at least not clean enough for the new health center. But some way the county had heard about it and lent a group of convicts to finish the job under the women's supervision. The floor was practically rotted out and there was a bad sill, but that was cared for, too. Then Mrs. Thomas K. Glenn and Mrs. Carl Hutheson offered to pay for both the paint and the labor to get the place painted. Now with it cleaned and painted, they had no furniture, not even a chair nor a table. Someone had the bright idea that the old Methodist Camp Ground might donate some benches. Sure enough they got three and Mrs. Adolphus could spare a couple of chairs from her house.

The PTA said they would contribute the dollar a month they would have to pay Mr. Fickland at the filling station for water. A group of women cleaned the back yard and planted flowers. Dr. Ferrier gave a swing for the children who would soon be coming to the clinics. The Sandy Springs Civic Club offered to buy some medical supplies through Mr. Jimmie Butler who could get them at wholesale prices. Then the county came through with a sterilizer and a few other items to meet absolute minimum needs.

It was at about this time, March 1940, that the Fulton County Health Department announced through the local press that it had opened a new health center at Sandy Springs. Dr. McGee stated that the health department planned the center as an office for the public health nurse, Merle Kennon, who had been assigned to that area and who would be in her office each morning from 8:00 to 8:30 and on Saturday until noon. Dr. McGee went on to say that Miss Kennon would make visits into the homes in the area to assist and instruct families where there was communicable disease, to assist mothers in problems of infant care, and other general public health nursing problems. It was also brought out in the interview that clinics would be held regularly for expectant mothers, well babies, and for the immunization of persons not able to be under the care of a private physician. Furthermore, Dr. McGee stated, these clinics were not designed to take the place of the free clinics for people actually ill but were largely for preventive services. He couldn't tell so early just when the clinics would begin but Miss Kennon could be asked at the center for this information. Again he emphasized that the chief objective of the center was to teach mothers the proper manner of tending their babies so that their offspring would prosper by means of proper treatment and under proper sanitary and hygienic conditions.

And so began the work of the Sandy Springs Health Center. For the next year Miss Kennon (who, by the way, is now better known to us as Mrs. Lott, popular area supervisor of nursing services) began a program of health education and services that certainly did much to prepare the way for our center as we know it today. In the beginning unbelievably bad conditions were found in the homes. Babies' bottles swarmed with flies and babies died with "summer sickness." Sterilizing the bottles was an almost unheard of practice. Doors and windows were unscreened and it was Miss Kennon who suggested that where there wasn't money for regular screens, mosquito netting could be used as an effective substitute. It was common practice for babies to sleep in the bed with both parents and when the necessity for a separate bed for the baby was mentioned, there was often the problem of no money to buy a bed. Here again the Sandy Springs Civic Club came to the rescue, getting material and a carpenter, who under Miss Kennon's supervision put on a demonstration for parents in the community to show how easily

a home-made bed for the baby could be evolved.

This program of work was continued under Ruth Marsh, who followed Miss Kennon, and her successor, Mrs. Nan Barrett. It was under Mrs. Barrett's administration that the Sandy Springs Lay Committee was born. The local women and various organizations from the beginning had continued to help all they could, but since it was no one's direct responsibility, the ones closest to the center were carrying most of the load. For instance, on particularly cold mornings Mr. or Mrs. Adolphus, who were near, would run over to get a fire started before the nurse came. When a cleaning was indicated, or mop or broom was needed, there was no money for it. Then there were bigger things that the center needed terrifically if it was to function efficiently, so the formation of a Lay Committee to raise money, among many other duties, was inevitable.

Mrs. Adolphus was the first chairman. Mrs. Payne, the first secretary, also had artistic abilities and almost immediately put on a program of music and dancing. "Backyard Follies" they called it, for it was staged against a white picket fence on which red roses climbed. From this the Lay Committee cleared $50. There wasn't much discussion as to how that money was to be spent. The health center was being so enthusiastically received by this time that the three benches from the Methodists and Mrs. Adolphus' two chairs were not enough to seat those who came and patiently waited their turns at the clinic. So the $50 went for new chairs and precious few it bought for the 1944 prices had already started to go up. It's in the minutes how Mrs. Watkins, the first treasurer, took her truck and went to fetch the chairs to save the cost of transportation.

Mrs. Watkins was elected president of the Lay Committee in its second year, and by this time there were 17 members. There had been discussion for some time of a possible bazaar, —purpose, money. So shortly after Mrs. Watkins' inauguration, a May festival was put on. The whole community participated to make this a success. Hammond school offered its facilities but refused to share in the profits. Women contributed cakes, jams, jellies, and flowers. Men built booths. There was a fish pond and everything else anyone could think of to make money. Result—more than $200 clear profit.

SO IT WENT. As we glance back through the minutes, we realize all the thought, planning, and work required in those war years for each step forward—all the months it took even to get a telephone installed, the weeks and months of telephoning here and there before scales could be found, a new sterilizer, and finally an electric refrigerator.

Sandy Springs is so glad to tell of her experiences, for in them we feel others may find inspiration and encouragement. Our experiences will not be yours, of course; nor will your health center be a duplicate of ours. From its embryonic stage to the strong effective civic body your center will ultimately become, your pattern of growth will of necessity be different, though no less vital to your community. You will surely contribute immeasurably to that healthier, better life of which we, as an intelligent democratic people, have already caught a vision. As a newcomer, I can without fear of boasting, recommend to you the spirit of service and enthusiasm that has characterized the Sandy Springs Health Center from its very inception.

One day Archibald Rutledge asked an old Negro how he'd ever managed to make a thing of shining beauty out of a filthy, rusty, old tugboat engine. The old fellow answered, "I'll tell you how it is, Mr. Rutledge, I've got a glory." So that was it—he had a glory. Why that's what we all need, thought Mr. Rutledge, and thinking about it he wrote:

Oh, you gotta get a glory
In the work you do;
A hallelujah chorus
In the heart of you.
Paint, or tell a story,
Sing, or shovel coal,
But you gotta get a glory
Or the job lacks soul.

O, Lord, give me a glory.
Is it much to give?
For you gotta get a glory
Or you just don't live!

The great, whose shining labors
  Make our pulses throb,
Were men who got a glory
  In their daily job.
The battle might be gory
  And the odds unfair,
But the men who got a glory
  Never knew despair.

Oh, Lord, give me a glory.
  When all else is gone,
If you only got a glory
  You can still go on!

To those who get a glory
  It is like the sun,
And you can see it glowing
  Through the work they've done.
Oh, fame is transitory,
  Riches fade away,
But when you get a glory
  It is there to stay.

O, Lord, give me a glory
  And a workman's pride,
For you gotta get a glory
  Or you're dead inside!

This sort of glory, I believe, is the thing that saw Sandy Springs Health Center through those early difficult days, and shrouds it in the warm humanity that characterizes it today under Miss Murphy, the present administrator. I only wish there were time to bring our story up to date—a truly amazing record of accomplishment. You'll just have to come and see for yourselves, bearing always in mind that what Sandy Springs has done, so can you.

MY VNA EXPERIENCE

AT THE CONCLUSION of my two months service with the Visiting Nurse Association of Yonkers, I feel that my understanding of just what public health nursing is, has been greatly enlarged. Actual physical care of the patient has always been to me a great source of satisfaction. Now coupled with the wonderful opportunities that present themselves for teaching, it is doubly enjoyable. It seems to me that a program such as this with both morbidity service and family health supervision and teaching gives the nurse a broader outlook and a better understanding of the problems that arise when sickness problems occur in the home.

This experience came after six months of official agency work, but the actual adjustment to the home technic was a comparatively easy one. I find that morbidity work in the home is very challenging. I like the chance it gives to improvise when necessary and the thought and planning it takes to change simple household items into usable hospital equipment. I also found the complete acceptance of the nurse by the patient and family, because physical care or injections or teaching technics were vital to well-being, a new experience. Their reaction to communicable disease and health supervision work which I noticed when on health department service had not always at first been favorable. Watching the greater freedom in the working of the voluntary agency has been most interesting. Even the insurance situation and payment for visits which I dreaded at first has become relatively easy because I am better able to explain the agency policies, its financial set-up and needs to patients and their families.

In conclusion I would like to state that the past two months in public health have been my most enjoyable and have determined for me what my future in public health is to be, a combination of morbidity service and health supervision. It has been a completely satisfying two months. Time has passed too quickly. The kindness and heartfelt cooperation of the entire staff has made the affiliation the "stand-out" of the many services with which I have been associated both in training and in postgraduate work.

JOAN MCDERMOTT, R.N.
APPRENTICE PUBLIC HEALTH NURSE
YONKERS, NEW YORK

TUBERCULOSIS NURSING ABROAD

After attending the Congress of the International Council of Nurses in Stockholm I spent four weeks observing tuberculosis services in Sweden, Norway, Denmark, and England. The following observations from my notebook touch briefly on some of the high points of these services.

Sweden, Norway and Denmark

The Scandinavian countries are justifiably proud of their tuberculosis services which are in advance of those in most countries. Their preventive services are particularly progressive and well organized.

Chest clinics are like busy industries, yet patients seem relaxed and I never saw larger numbers of people waiting to be examined. Clinic buildings are beautifully designed, attractively decorated, with flowers, plants, and pictures and all have comfortable chairs. The examining rooms are models of efficiency and privacy for the patients.

In nearly all of these clinics children are examined in separate rooms and have separate waiting rooms. In the Central Dispensary in Stockholm, there is a separate entrance to the children's department. No adult known to have tuberculosis is allowed to escort children to clinic. Children who are known to have been in contact with tuberculosis are examined on different days from those children who have not been exposed.

BCG vaccination is encouraged for all individuals who have a negative tuberculin test. Norway has a law making BCG vaccination compulsory. The law has been in effect for 2 years but it is seldom necessary to enforce it as most individuals willingly accept vaccination. One tuberculosis control officer told me that over 90 percent of the school children in his county, just outside Oslo, have been vaccinated. He explained that there were many ways to have parents obey the law without resorting to force. For example, just prior to the first mass BCG vaccination program among school children he wrote letters to their parents explaining that such a program was soon to get underway and that the children would be included in it. He asked the parents to write him if they had any questions, and, if he didn't hear from them, he would assume that they understood and approved of the vaccination program to help to protect their children from tuberculosis. The doctor said, "You know, I got practically no letters, people so hate to write them."

Preschool children examined in chest clinics are given health cards which show reports of BCG vaccination, exposure to tuberculosis and other significant health data. These cards are kept by the parents and are shown to the examining physician whenever the child is examined, at home, school, physician's office or clinic. Each doctor adds any information which would be to the interest of the child if another physician were to examine him.

Almost every doctor with whom I talk asked me to go home and preach the need for BCG vaccination. Many nurses asked why we in the United States were so slow in accepting it. I was impressed with the reports that were given to me.

Tuberculosis hospitals in these countries are as beautiful as the chest clinics. They are light and airy, with flowers blooming and plants growing on window sills inside and outside of the buildings. The patients have well equipped lounges, smoking rooms, and recreational halls. There seemed to be very little vocational rehabilitation work being done in the hospitals, although most of the hospitals have modern occupational therapy rooms.

Nursing service to tuberculosis patients and families is provided by all of the chest clinics. The nurses are specialized in tuberculosis in the cities. However, they may or may not

have had previous experience in tuberculosis nursing. Generalized nursing services are usual in many of the rural communities. Nearly all of these countries hope to have generalized nursing services within a few years.

Denmark was the only country which had nurse directors in the chest clinics. Physicians were in charge of the nursing services in the other countries including England. I asked one medical director in England if there was a supervising nurse, nurse in charge, or matron (director) in the clinic and he said, "No, they do not need a nurse to direct them and to tell them what to do."

The nursing care in the hospitals seemed good to me. Precautionary measures, such as gowns, caps, and masks are seldom used. Handwashing facilities are inconveniently placed in most instances and common towels are used in every country. Patients had cotton handkerchiefs and placed them in a bag beside their beds. No paper towels or paper handkerchiefs are used because of the paper shortage. I felt that the BCG vaccination was overly depended upon to protect the personnel against tuberculosis. While it is one important measure it is not the only one that should be used. There were no figures as to the number who contracted tuberculosis among the staff of the tuberculosis hospitals.

The teaching of patients and families in their homes by the public health nurses seemed sketchy to me. I could not understand their language, therefore I was given a résumé in English of the home visits I observed in Sweden and Denmark.

ENGLAND

The tuberculosis services in England are a far cry from what I observed in the Scandinavian countries. The preventive services seemed particularly inadequate. They are doing some interesting things in England however. For example, because of the shortage of hospital beds, several of the chest clinics have started what they call "domiciliary care," in which pneumothorax treatment is instituted at home or at the clinic for carefully selected patients. Housekeeping service is provided as well as public health nursing service. The clinics are becoming predominantly treatment clinics. The public health nurses and health visitors with whom I talked were quite frustrated because they had so little time for teaching patients at home. There is great need for this type of public health nursing service.

Most of the hospitals are very old. Some are splendid buildings, but I can imagine it is hard for the nurses to get their work done without a lot of extra time and steps. The patients had excellent care. There is a nice relationship between the matrons, sisters and patients. One matron who had been to the United States said she was amazed and horrified at the lack of mutual regard between directors and others in the "higher echelon" and those in the head-nursing and general nursing positions. She said, "You know, here the ward sisters are kings in their wards and I wouldn't think of taking a guest through the hospital without first introducing each sister. The sister would then show us her ward." She said she was never introduced to the head nurse in the few American hospitals that she had visited, and the head nurse was usually ignored by the person who was showing the visitor around.

All the countries that I visited were faced with the two serious problems that we have in the United States—nursing shortage and lack of student affiliation programs to prepare nurses for basic tuberculosis nursing. Many of the hospitals were working hard to get tuberculosis nursing experience into the basic curriculum.

The hospitality of the nurses in every country was magnificent. They shared their rationed food with me and in some of the countries there was mighty little to share. One felt that nothing was too much for them to do to make their visitors comfortable. The nursing organizations and the individual nurses and doctors who took time from their busy days to explain their work and show it to me have my warmest respect and thanks.

JEAN SOUTH, R.N.,
CONSULTANT NOPHN
JOINT TUBERCULOSIS NURSING
ADVISORY SERVICE

INTERVIEWING IN A HANDICAPPED CHILDREN'S PROGRAM

MARY ANNE FRENCH, R.N.

THE CLINIC interview is of primary importance to the public health nurse. The nurse making a home visit may find the family on the defensive, ashamed of its living conditions or housekeeping, harassed or preoccupied. When the family comes to the clinic, it comes as a guest ready to be welcomed and usually planning to discuss its problems.

To interview successfully, the public health nurse must be able at all times to see the patient as a member of the family unit and the family as an integral factor in the community. This is particularly important in working with the handicapped child for one may assume that the child has more than the normal adjustments to make in the family household and that each member of the family also must make special adjustments to him. When the child branches further afield into the life of the community, his difficulties are multiplied if he hopes to take any part in that life. Not only are his feelings toward his family and his family's feelings toward him involved but also his varying abilities to compete on equal terms with his contemporaries for a place in the sun and his reaction to his relative successes or failures.

The nurse has as her main objective helping him to as much success as his best abilities can achieve along the lines best suited to him and helping him and his family to an objective acceptance of his inevitable failures, without resentment, self pity, or feelings of guilt. This objective may be partially achieved by assisting the family to an understanding of what its real problems are and what type of help may be expected from the clinic services, and by making available to them other community services.

The primary function of the first interview is to obtain a working knowledge of the family and to give the family a working knowledge of the clinic and what it offers. An underlying purpose is to feel out the family's attitudes and psychological approach toward help. Certain basic questions kept in mind as the conference progresses will assist the nurse in gauging the family's attitude:

Was the patient brought to clinic voluntarily or was the family "pressured" into bringing him?

Does the guardian talk freely or only in reply to direct question; does he talk too freely; does his conversation indicate that he is thinking primarily of the child's welfare, the family's welfare, of what the neighbors think or will think?

Does he seem over-protective of the child? How does he handle him—by commands, by suggestion? Is he rough in dressing and undressing him?

How much knowledge does he have of the normal child's growth and development; how nearly does he approach an understanding of the patient's condition, potentialities, and future? Does he know the patient's prognosis and if not, how much of that prognosis can he bear to hear?

Mrs. French is liaison nurse in the Crippled Children's Service, District of Columbia Health Department, Washington, D.C.

Does the family really want help and if so how much help can they use and at what level should it be offered?

While the nurse is holding these questions in the back of her mind, she is introducing herself and the clinic, discussing clinic schedules, hours, the doctor's name, what the doctor will do, and what information he will need from the family to assist in diagnosis and treatment. A generalized conversation of this sort tends to put the patient's family at ease and induce them to talk readily and to the point.

Following the doctor's examination and diagnosis, the family is usually ready to ask questions and to discuss proposed tests to be done, x-rays to be taken and plans for future care. There are certain stock phrases that help the family to accept advice: "We have found in other cases similar to your child's that the application of night splints is wise"; or, "Have you noticed that Johnnie has slipped back into some of his baby habits; most children of his age do," or, "What would you think of trying not to notice Johnnie's difficulties in muscular coordination—do you think he would do better if he felt that he were not observed?" These are a few of the many approaches to persuading the family to participate in planning and thinking and working for the patient's welfare.

Time and again we have discovered that a mother will accept plaster boots for her baby's club feet if she knows that there are six other babies receiving the same treatment in the clinic and not minding it at all. By accepting the treatment herself she brings acceptance to the baby. We never assume that the family understands the reason for a test, whether simple or complex. Rather, we always offer the explanation as knowledge the family probably has but would not object to reviewing.

A CHILD'S physical handicap is often easier for the family to accept than a mental one, we have found. And it is easier for the mother to accept a child's physical handicap than it is for the father, especially if the child happens to be a boy. A handsome and intelligent little boy who was a cerebral palsy patient and was learning to walk at our clinic here, had been completely rejected by his father, an Army flyer, who had wanted a shortstop for a son. It took the combined efforts of the staff over a period of months to give the son value in his father's eyes and to persuade the mother that her boy needed to grow in independence.

Sometimes the family is able to accept a finding of mental deficiency when it is presented to them as a relative matter, backdropped against the society in which the patient happens to live—that each individual has his own individual abilities, physical and mental, and that if the family helps the patient to a fulfillment of these abilities, the patient has lived richly. Frequently the family has a feeling of guilt in relation to the patient's condition and relates the patient's disability to some real or imagined sin committed in the past. As a result, the parent is over solicitous and over attentive to the patient, hindering rather than helping the growth of independence.

For example, one of our small patients, aged 22 months, is seriously malformed. One foot is missing, the other clubbed, there are no fingers on the left hand, the palate is cleft, and in addition to other congenital anomalies, a severe mental retardation was apparent at an early age. The mother was convinced that she was directly responsible for the baby's condition as she had divorced her first husband and married again despite disapproval of her church and family. She considered the baby God's punishment for her act and her expiation complete 24-hour devotion and servitude to her little daughter. Much of this we learned gradually though it was apparent to the public health nurse at the first interview that the mother was carrying a heavy burden of guilt expressed in her abnormal devotion to her child.

At first any attempt to interpret the baby's condition in the light of medical knowledge was blocked because she had a perfectly formed 11-year-old boy by her first marriage. This to her was the ultimate in proof. Before her sin, she had borne a normal child; after it, an abnormal one. We first managed to insert a wedge in this seemingly complete mind block when the mother agreed with the nurse that no one would blame a tomato plant for bearing an imperfect tomato. This grudging admission was made only after we in the clinic had been working with her for over six months; had treated her daughter not only for her congenital deformities but for successive upper respiratory infections. The mother knew us, trusted us, and over a period of weeks was able to talk to us and bring us some of her problems. It is doubtful if she will ever be able to view her younger child's condition objectively and accord to her only that portion of her attention to which she is entitled as a member of the family group. How-

ever, she has been able to go to an evening movie or do an afternoon of shopping, leaving a baby sitter in charge; and now she and her husband are planning on football games this fall.

In cases where the child's growth potential is so low as to make institutionalization advisable, it is frequently necessary for the parents' peace of mind to have the doctor order them to place the child in an institution. In this way, by avoiding responsibility for decision, they also avoid the burden of guilt that the decision might bring. In cases of this type, the public health nurse plays an important part in interpreting the parents' need to the doctor and the family's adjustment to the situation.

This assumes a close working relationship between the clinic doctor and the nurse.

A case in point occurred this summer. An intelligent young mother brought her mongoloid baby for a medical diagnosis and conference. Prior to her appearance, the nurse in the field who had referred the patient, talked at some length with the nurse in the clinic as to the general family situation, stating that the father in this home was able to see all sides of the situation and was eager to have the baby institutionalized. The nurse was certain that the mother would welcome it if the responsibility for the decision was taken out of her hands. The nurse discussed the overall picture with the doctor before the baby was examined. As a result the institution was not offered as a plan that the family might consider in the future but as care the patient should have immediately, not only for his own sake but for that of the two older children in the family. The nurse had been careful not to sound out the mother's attitude toward an institution prior to her conference with the doctor so that the mother was able to accept the doctor's recommendation as from an independent authoritative source and follow it with a clear conscience. The doctor, armed with information from the nurse, was able to recommend the best course in a manner which the family was able to accept.

On the routine side, the public health nurse knows the community resources. She arranges for the hearing test; recommends shops where corrective shoes may be purchased; knows where the Recreation Department has summer programs underway; what clubs are available for different age interests; what the schools offer in the way of speech therapy and where else it may be obtained; how long the waiting list is for a conference for public assistance; what the Board of Public Welfare offers in medical care to dependent children. To those sources to which the family is referred, pertinent non-confidential information concerning the patient is sent. An overall liaison job is done.

In our interviews, we endeavor to have the family as a whole the subject of the interview—not the patient alone. In discussing why Johnnie will need to wear casts for two or three months to prepare his feet for corrective shoes, the public health nurse is also aware of sister Jane, age six, who is busy sucking her thumb and massaging her ear. She works into the conference some discussion of the needs of a six-year-old in security, in range of interests, and in recognition and approval. Perhaps Jimmy's rickets bring about a discussion of the family's meals, general budgeting of food money, and basic food requirements. In any case, the nurse brings to the conference all her knowledge and all her skill to help the family to a fuller, healthier, happier life.

ANY DISCUSSION of conferences would be only sixty percent complete without a discussion of records and record keeping. I recall when I was working with an agency which had an extensive nursing education program an older nurse who was studying at the local university for her Master's Degree was under my supervision. After we had worked together for a week, she explained to me that there was no need to go into the different phases of our work at the agency, that with her long experience the one thing she wanted to learn was the knack of turning out the type of records for which we were acclaimed. She was with us sometime before she realized that one had to have the visit content before one could have the record and that one first had to be able to "see" the family picture before one could get it down on paper.

For good records, one should of course have adequate clerical help. Unfortunately, that is something that is not too often available to the public health nurse. It is much easier to keep full and accurate records if one can dictate them and leave the matter of getting them typed, punctuated, spelled, and into the patient's folder to one whose primary job it is to do so. Records are bound to be shortened and distorted when the public

health nurse's hunt and peck typewriting methods get in the way of her mental processes.

Most public health nursing agencies have a family folder of some type on which basic family data, such as income, education, housing, and the like, are placed. With a family data form of this type, we try to give a continuity and substance to each conference with the patient. As in working with a maternity patient, when the nurse lays out a flexible plan to cover certain points during the course of pregnancy—perhaps one time discussing family preparations for the baby and another time the birth process, so in our handicapped children's group, we try to define on paper the family's needs and attitudes and indicate along what lines we plan to work. This enables the public health nurse who sees the family on the next visit to avoid pitfalls and to start from the point at which the last conference stopped. She thus inspires the family with confidence and gives continuity to the orders of the doctor and other help given.

As all our records are typed or written in triplicate, the field nurse, the school nurse, and the nurse in the well baby clinic are all kept informed of the work being done with the handicapped child. The public health nurse in the clinic similarly receives reports from the field as to the patient's adjustments, home conditions, and other pertinent information. In this way duplication of effort is avoided and continuity of treatment made possible.

Working with the handicapped tends to be a rather frustrating experience, if the public health nurse expects more than partial results. If she can recognize the most minute improvement as success and bear in mind always the old adage that "many a mickle makes a muckle," she will find working with the handicapped a singularly rewarding experience. This enrichment will heighten her professional skills, giving her patience and a broad tolerance in her interviews.

THE VISITING NURSE IN THE VOLUNTARY AGENCY

FOR THE GOOD of our town we all want the Visiting Nurse Association to recognize changing needs, to be in a position to meet them, and to be flexible enough to take advantage of new knowledge and better ways. We want her to do well whatever her budget allows her to do.

The role of the visiting nurse in the voluntary agency, as I see it emerging, is the giving of personal service to individuals trying to cope with specific situations such as illness, pregnancy, or caring for a baby or little child. Such service must be sensitive to the particular pressures the individual is feeling, be they physical, emotional, environmental, social or financial, the visiting nurse using all the insight and resources of her profession to help him ease the strain. Furthermore she must be aware of needs beyond her competence to meet and skillful in gently introducing the patient to other social agencies which he may find helpful. And as the idea grows of teams of workers from different disciplines working together to give complete service she will more and more be called upon to become a working partner. All of this calls for a depth and richness and sensitiveness of service far beyond the early stereotyped pattern and constitutes an exciting challenge to visiting nursing.

ELIZABETH GORDON FOX, R.N.
—From remarks made at a dinner in her honor, New Haven, Connecticut, October 19, 1949.

THE GRIFFIN PLAN

LESTER M. PETRIE, M.D., LILLIAN BISCHOFF, R.N., AND JOSEPHINE KINMAN, R.N.

THE COORDINATED industrial health program in Griffin, Georgia, is conducted jointly by the County Health Department and the local industries. "The Griffin Plan" has been in operation for several years. It is designed to utilize local public health personnel in the industrial plant and community. The plan and program as it has evolved has been very satisfactory.

Griffin is the county seat of Spalding County, located in the rich peach, pecan, and cotton growing section of the state. Griffin has a population of nearly 20,000 while the county has approximately 29,200. About 7,000 persons are employed in the 20 textile and subsidiary mills, 1,000 in the food processing plants, several hundred in other miscellaneous plants in and near the city. Some 115 technically trained research men are employed by the Experiment Station of the State Department of Agriculture. The other major occupations are farming, dairying and fruit growing.

The Spalding County Health Department is part of a Tri-County Health District. Prior to "The Plan," the generalized health department program provided services in schools and met some of the needs of the families through the central maternal and child health and

Dr. Petrie is director of industrial hygiene and Miss Kinman, industrial nursing consultant, of the Georgia State Health Department. Miss Bischoff, associate director of the state's public health nursing, is on loan as nursing director of the Grady Memorial Hospital.

tuberculosis clinics. The health programs of the industrial plants were independent of the health department and medical society. In fact, the present program is the outcome of certain ethical and relationship problems that developed among various persons concerned.

This is the factual story of how public and private health workers and officials of the local textile mills in Spalding County took action to have an effective health program for the entire community.

In 1946, Mr. H. A. Pickford, general manager of the Crompton-Highland Mills, advertised for an industrial nurse. Dr. T. O. Vinson, health commissioner, saw this ad and called on Mr. Pickford to discuss qualifications of industrial nurses and other problems. The idea of utilizing the generalized public health nurse to service the plant and mill village evolved from this meeting. The state director of the Georgia Division of Industrial Hygiene, the local medical society, the regional nursing consultant, the local supervising nurse, and the plant executive, consulted with Dr. Vinson to develop details. Before the plan was crystallized, Dr. Vinson visited various similar industrial areas throughout the state to study their health services. The present agreement provides:

1. The Spalding County Health Department shall assign a generalized public health nurse, for a part of each day, to serve each industrial plant.

2. The industry shall contribute its proportionate share of the nurse's salary to the health department.

3. The nurse shall be supervised by the Spalding County Health Department.

4. All medicines and treatments administered in the plants and in the homes shall be on an individual basis and only on a prescription from the family physician.

5. First aid and other procedures shall be carried out according to written standing orders approved by the medical society.

6. Accident victims and persons found to have signs and symptoms of disease shall be referred to private physicians as indicated.

One activity of the nurse is to make physical inspections of prospective employees. The inspection includes vision and hearing testing; blood pressure reading; temperature, pulse and respiration recording; and observing the individual for obvious physical defects. A blood specimen is drawn for serological test; hemoglobin concentration is determined; and the urine is analysed. If indicated a sputum or stool specimen is sent to the state laboratory for examination. Arrangements are made for chest x-ray in the Health Department. The x-ray machine is taken to each plant at scheduled intervals during the year at which time all personnel are x-rayed. (Each plant gave $1 per employee as a contribution toward the purchase of the modern photofluorographic x-ray machine.)

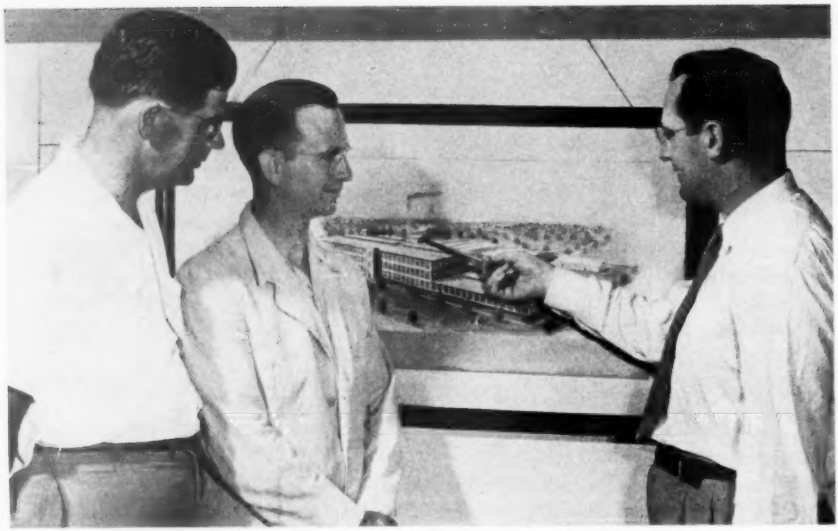
All positive findings are reported to the employee's private physician. The nurse follows through on the physician's orders as indicated and works with local and state resources to help secure maximum rehabilitation.

Health rooms have been established in each of these plants and are used as nursing centers. Child health conferences are held in some of these centers; in other plants, the conferences are held outside. The Rushton Mill designed and built a health center where all persons in the immediate area are served irrespective of mill connections.

Crompton-Highland Mill is the only plant

TABLE 1. HEALTH DISTRICTS, POPULATION, AND MILLS IN SPALDING COUNTY, AND PERCENT OF TIME OF PUBLIC HEALTH NURSES ASSIGNED TO VARIOUS SERVICES

Number of employees	District number	Population	Mills	Industry	School clinics	Other clinics	Home visiting	Record keeping
800	1	3,000	1	25%	10%	9%	30%	26%
.....	2	6,000	.....	.....	15%	18%	35%	32%
700	3	3,200	1	25%	10%	9%	30%	26%
1,050	4	5,000	3	45%	10%	9%	16%	20%
.....	5	6,000	.....	.....	20%	18%	32%	30%
400	6	3,000	1	36%	10%	9%	20%	25%
1,050	7	3,000	1	36%	5%	9%	25%	25%
4,000	All districts	29,200	7	24%	11%	12%	27%	26%



Health Commissioner Vinson confers with industrial officials

which has a trained first aid worker in the nursing office during the nurse's absence. Other plants have trained first aid workers on various shifts who are called to the nursing office when an employee needs first aid treatment.

The Spalding County Health Department has 7 public health nurses assigned to the 29,200 population. Table 1 shows the size of the health districts and assignments of public health nurses in the county. One nurse is assigned to each district.

Since January 1947, when the "Plan" began, 5 nurses have been assigned to the 7 mills with 4,000 employees in 5 districts whose population is 17,200. This means that 59 percent of the county population is served by 71 percent of the nurses, but the industries' financial contribution offsets this proportionately greater service. A time study shows approximately 34 percent of their time spent in industry, 9 percent in schools, 9 percent in other clinics, and 24 percent in home visiting. In the 5 districts involved, 34 percent of the nurses' time is in industry which employs only 22 percent of the population. It must be remembered, however, that this service is reaching the family wage earners and through them the members of their household.

Many of the clinics for the local area are provided by the cooperative industries. The major difference between "The Griffin Plan" and other industrial and public health programs is the complete merging of the two. Few communities are without public health nurses and many textile mills employ registered nurses. We have seldom seen independent health programs united so effectively with the county for the benefit of the entire community.

Comments on the program by some of the participants may give some impressions of its value:

County Health Commissioner:—"Until the nurses were assigned to the individual centers, we reached only a few of these industrial people through our service and educational programs."

Nurse:—"It's hard work and poor pay, but it's good public health and I love it. The doctors are interested and give us good cooperation."

Vice President of Rushton Mills:—"The program is well worth the cost in giving employees peace of mind and a sense of security. They and their families and neighbors know where to turn in time of trouble realizing the resources of both mill and health departments are at their commond. . . . Success or failure of the entire program depends upon the nursing personnel."

Private physician:—"The medical society has discussed this plan on numerous occasions. When put

to a vote it was endorsed unanimously. I much prefer having the industrial nurse under medical supervision to having a free lance nurse under lay direction. It is a great convenience to us to have a nurse on the job to take care of emergencies until we can get there."

Employee:—"I am so happy to have the nurse here in the mill because of her personal interest in my health and that of my family."

We are the first to recognize that there are weaknesses in this program. Of major importance is on-the-job medical direction. Efforts have been made to secure part-time medical service from among the local medical group. Adequate educational advantages for the nursing personnel is another. Several nurses are in school now and others plan to study through the Extension Division of the University of Georgia. Other deficiencies both real and potential are recognized, but it is not the purpose of this paper to go into all these details.

A start has been made. The good features of the program far outweigh the poor ones. The present service, even with its inadequacies, is very much better than conditions prior to "The Plan." Had it been postponed until all imperfections were corrected, "The Griffin Plan" would never have been started. The enthusiastic local support has again demonstrated the truth expressed by Rosenau, "When young men have vision, the dreams of old men come true."

WORKSHOP ON TREATMENT OF POLIOMYELITIS

An institute on the Treatment of Poliomyelitis was held in Madison, Wisconsin, in the late summer for doctors and institutional and public health nurses. It was conducted by the University of Wisconsin School of Medicine and the School of Nursing and was sponsored by the National Foundation for Infantile Paralysis.

The parts of the program relating to the diagnosis, epidemiology, and community aspects of poliomyelitis were held jointly for all members. In separate sessions the nurses were given demonstrations and opportunities for practice in clinical procedures relating to the care of the patient in the respirator, in the application of hot packs, and in muscle reeducation.

In addition to the values derived from the many excellent presentations on poliomyelitis the meeting was important because of the opportunity it offered for integrated thinking about a complex problem between doctors, nurses, physical therapists, and occupational therapists. On a more extended community level the institute demonstrated a fine type of teamwork between the University, Medical School and Nursing School, National Foundation for Infantile Paralysis, State Board of Health, and the Bureau for Handicapped Children.

MARTHA R. JENNY, R.N.
ASSOCIATE PROFESSOR OF PUBLIC HEALTH NURSING
UNIVERSITY OF WISCONSIN

DO YOU WANT TO BE A LADY PROFESSOR?

Are there advantages in university teaching? Does work satisfaction compare with that in other public health nursing positions? Is part-time teaching worth while when one already has a good job and is not looking for more work? The writers give their answers to these questions and raise others in discussing university teaching from both a full- and a part-time point of view.

1. When It Is A Full-time Job

MARION MURPHY, R.N.

TEACHING in a university is a stimulating experience. One is immediately impressed with the fact that women have made considerable progress during recent decades in achieving status in higher education. Side by side with this realization, however, is recognition that sustained effort is necessary if such progress is to continue. Nursing, primarily a women's profession, is a case in point. Even the youngest instructor comes to feel that nursing is gradually gaining status in academic and professional fields, and can identify her own small share in such progress. Under stimulating guidance, however, she must constantly strive to enlarge her contribution and develop herself further professionally—women in universities cannot afford to "rest on their oars!"

At the University of Michigan School of Public Health Miss Murphy is associate professor of public health nursing. Miss Walsh doubles as part-time assistant professor of public health nursing at the university and as director of the Washtenaw County Health Department.

Working with students is a rewarding experience. There is opportunity to meet a select group of young nurses from all over the country and many other parts of the world, to plan for enrichment of their professional backgrounds according to individual need, and to see public health nursing anew through their eyes. The instructor soon finds that she is increasing her own appreciation of nursing education and public health practice as she confers with students who have had professional preparation or work experience here, there, and everywhere. The instructor tries to be objective about students just as, when a supervisor, she tried to be objective about nurses with whom she worked. She becomes aware that some able nurses show unusual strain under academic pressures; that she must know the whole person, not just a name in her class roll book. The instructor learns to evaluate students not only by what they say but by how they react, by the attitudes they have formed, by their hopes and plans in public health nursing.

There is a certain breadth of experience which the instructor gains on the one hand from the student and on the other from the university framework within which she functions. This experience cannot help but overcome provincialism in professional thinking. Challenged by students from California, Utah, Texas, Ohio, and New York, the instructor learns to be very objective in her statements concerning any particular state. I remember an early part-time teaching experience in which my time for preparation was extremely limited and in which I literally "lifted" my agency office into the classroom. I did not lack for material but now fear that my students were indoctrinated rather than allowed to do much thinking for themselves.

University teaching positions usually provide security in the way of tenure (depending upon rank) and retirement benefits which are at least comparable to those available in other public health nursing positions. Many factors influencing our living today have made even younger nurses extremely aware of such benefits or lack of them in considering positions. Beginning salaries in teaching positions are apt to be comparable to those paid in supervisory or consultant positions in the same geographic area.

Most university communities offer cultural advantages which add to one's enjoyment of living. Music, art exhibits, drama, lectures, and other interesting events are usually available in good quantity and quality at moderate or low cost or without charge. I would like to interject a hint of caution, however, by saying that it is my ambition to remain in a certain university community long enough to have time to take advantage of all the above named activities! Whether or not one can attend each lecture or concert, it is nice to know that such pleasures are available there when one *does* have time.

Not most important but quite interesting is the status which faculty association with a great university gives one. Most public health nurses have had the experience of finding it difficult to impress even the name of their agency on their families or non-professional friends. There seems to be something magic about the name of a university. At least, it is easily remembered and is usually good for some casual conversation even with strangers. In the smaller university community, landlords, banks, and shops are apt to be favorably impressed with university clients—even one's cleaning woman may prefer to work only for "university ladies!"

How does one go about preparing for university teaching—how determine if one is the right sort of person for such a position? Probably few of the nurses holding teaching positions today prepared for them deliberately, and considerable difference of opinion exists as to what course of action is the best to pursue.

The qualifications stated by the National Organization for Public Health Nursing define certain experience and time requirements which certainly would seem to be minimal. I would like to make a stronger plea for broad experience including administration. The nurse who has been a successful administrator or even an assistant has usually developed a broadened point of view. The nurse with such experience has had to cope with many situations which a supervisor may not have encountered and her objectivity should be increased as a result.

Time, however, is important and many universities have age limits for new appointments. If a nurse is interested in teaching, she should explore the possibilities early and plan for a wide variety of experience under the guidance of someone thoroughly familiar with both public health nursing and university policies. Probably most of the public health nurses in teaching positions today left a field agency regretfully. There is always the temptation to think that one would like a university position perhaps in five years, but not right now. Remember that universities are interested in younger people—don't plan to retire to a campus! There are exceptions, of course, and the writer would not venture even an opinion on how young is too young or how old too old! Physical health and energy should be given serious consideration among qualifications for a teaching position. The hours are apt to be longer than in many more standardized jobs and there are numerous extra demands on one's time. Moreover, uni-

versity faculties are not apt to have much control over periods of work pressure such as may be possible in field agencies.

THE INTERESTED candidate is often concerned about what will happen if she does not find teaching enjoyable—or if her adjustment to the requirements of the job is not of the best. Why should this concern be greater in contemplating a university appointment than any other position of responsibility? Why not remove the halo from teaching—and consider it one of the many interesting, stimulating possibilities among public health nursing positions?

The main problem which all public health nurses entering teaching have to face sooner or later is the lack of understanding on the part of field people as to what university teaching is all about. Specifically, criticisms from the field take two main lines, first, that faculty people need to be closer to the field and, secondly, that the university is slow about making changes suggested by the field.

I would certainly agree that public health nursing faculty members should utilize all opportunities to keep abreast of field developments. One wonders, though, if the critics give credit to the following points. In the first place, universities try to appoint public health nursing faculty members who have had varied and acceptable field experience before coming to the university. Thereafter, through close contact with field training centers, visits to other agencies, conferences with students and visitors, meetings, and constant reading, the faculty person keeps up her knowledge of the field the best she can. The truth is that the full-time faculty person is so busy that she cannot be two places at once!

UNTIL ACTUALLY accepting a university appointment, most field nurses have little concept of what a faculty person does with her time when not in the classroom. Conference time for students has high priority, preparation of materials, evaluation of students and programs plus necessary contacts with other units of the university and with the field agencies fill her working week to overflowing. University, local, state, and national committees claim some of her time. She sees a real need for research in many areas but may have too little time to explore the possibilities. Selective admission of students involves many hours of careful review of applicants' records and could easily take the full time of the program director—but that is only one of her many duties!

Field nurses who give an occasional lecture in a university classroom usually find the experience a pleasant one, but may not realize that even a series of pleasant and good lectures does not constitute a teaching job. Those who propose a system of rotation for public health nursing education whereby faculty and field training center personnel exchange periodically, have little concept of how educational standards are defined or maintained and that teaching is an art which most university professors have to develop through experience. I grant that faculty people should avail themselves of every possible opportunity to keep in close touch with the field, if nursing is to have status in universities comparable to that of other departments, but someone has to keep the home fires burning and make a career of professional education!

Careless comments from nurses in field agencies may have been the cause of well prepared candidates refusing university appointments—after all, who wants to be an "academic fuddy-duddy" or "has been?" Sometimes these comments border on the humorous. Only six weeks after I left an active field supervisory position to accept a university faculty appointment, I met a supervisor from a field agency who said, "Come and visit us soon. Why, I'd even arrange for you to go out in the field with some of my nurses—it would help you to keep up-to-date."

THE CRITICISM that the university is slow about making changes suggested by the field cannot be met as directly. No matter how firmly established, nursing is still only one department in the university framework and has to abide by certain basic policies and patterns. A university has channels similar to those of any other large institution and nursing and other departments must conform

until cause can be shown—via the proper channels—that the pattern should be changed. There is and can be continued progress—but there has to be patience, also.

In summary, university teaching is a challenge. Younger instructors may find that even pages of fine lesson plans and the most up-to-date bibliographies can let them down although these things have a place in teaching. But when the novice can look up from her lesson plan and see the students there before her—students with individual hopes, dreams and problems—then she is beginning to be a teacher. I hope that as younger nurses enter the teaching field, they will accept the challenge and welcome, with enthusiastic humility, the opportunity to interpret public health nursing to students of the future.

2. When It Is A Part-time Job

PATRICIA WALSH, R.N.

THERE ARE some of us at this time who do not have complete identification with either a university or a field agency on a full-time basis, but have been given opportunities to develop a job which combines a bit of each. Such assignments exist to some extent in many professional fields and with careful direction can be maintained within certain limits. We are in somewhat of a favored position in many respects. We provide the answers as some might see it to those who hold that university instructors need to get out of their ivory towers and learn what is going on. We often fail to see that the people in field agencies may have their own peculiar variety of ivory tower and may be just as successful at walling themselves into it. The instructor who comes into the university for part-time teaching from a field agency must be careful that she not let herself feel too reassured about the unusual advantages of such a dual position. For her teaching, if limited narrowly to recounting activities of one agency will result in restricting the development that students should expect in a university atmosphere. However, if the instructor uses the position as a vantage point from which to bring fresh material from the field for analysis, review, evaluation, and consideration of methods, the student may fortunately find herself exposed to practices that may be adapted to her own work situations. There are some professional workers who talk as though they would put all university teaching on this type of part-time instruction. If asked to agree to a similar recommendation for staff in all field agencies, they would immediately classify the suggestion as impractical.

Carrying a teaching job on a part-time basis is in many respects similar to the situation in which a student on the same plan finds herself. Many public health nurses have lived through that when carrying school and work assignments simultaneously. You can fill in for yourselves what it means to have divided responsibilities, variations in interest, concern over progress in either area, worry over meeting a deadline for a term paper, concern that unanticipated field activities may necessitate missing class or that class schedules will break into what should be productive field time. At the same time you counter that the two can be joined as you recall with pleasure how much meaning class work had when current field situations helped you to interpret theory a little more intelligibly; how you were able to

analyze your work situations from a different point of view after studying fresh material in public health nursing. The combination gave you heightened understanding—you felt it came more quickly; it did not need to wait until the semester ended so that application might begin. You used material immediately and thus it became part of you more easily. And that was good, you say. Yes, it was, and many profited by opportunities existing within the situation. Yet, is it ever possible or desirable to substitute entirely for full-time in the university? There is time then for more thoughtful study and review of material; for the browsing that so often results in our turning up priceless material not necessarily related immediately to our chief concern but so valuable in broadening outlook. There can be provision for more meaningful study, with the steps toward understanding being taken more thoughtfully and with a little more certainty. There is time also for the important associations that may be expected to characterize college life.

Considerations like these confront the instructor as well as the student. The two aspects may be brought together to advantage when there is clear definition of responsibility regarding each portion of the job. It is likely that one portion of the assignment may be the major one—in my situation it is the field task.

Even though this is true, the teaching responsibility cannot, therefore, be such a subsidiary that it is neglected. The university and those connected with it would be cheated in such an arrangement and truly the instructor would also lose. Nor must the agency feel that it is losing its employee to the teaching institution. In this type of position where one finds oneself with what may amount to two jobs, consideration in selection of activities becomes a perennial factor. One feels the need of developing the ability to weigh the importance of each phase of work so that emphasis goes first and in proper balance to the most significant items.

THE VALUES to be gained from such a combined plan of work may be very satisfying. Personal factors such as improved salary and prestige in a professional field are part of the picture and should not be discarded lightly or considered too casually. Nor should the realization that association with the university opens many more doors to employment opportunities. That may hardly appear to be an advantage when professional workers are haunted with job offers. It does present the opportunity to make choices even though one must accept the accompanying turmoil. As she develops her teaching and discusses theories with students, she has at hand the laboratory situation where these ideas may be tested. By including field observations the students may see how classroom instruction is translated into action. Teacher and student can view together how ideas work. They also perceive the need for certain modifications in going from general considerations to the specific activity and recognize that even within one agency practice will vary from time to time and even within a single day. What better teaching material exists? Actually, it is difficult to rival it. It is an invitation to teaching to become more alive. What a singular opportunity, too, for the student to put the instructor on the spot!

The instructor who learns to be objective about practices in her own agency will naturally become less protective of them. She can open the way to evaluate them regularly. She can encourage this practice among students through her own readiness to appraise activities. Students come to the university to receive new ideas, but they are not ready to accept rigid unchanging patterns. The student who feels free to present ideas in the belief that they will be welcome is preparing for work in a group situation where people may learn together. The classroom will influence the field program and the latter will in turn wield its influence on the teaching. The instructor who can discuss program and activities with students is in condition to expect the same thing from staff members in the field agency. One experience may be a control on the other and each should improve as a result. The instructor has much to gain from students as they express points of view. She gains, too, in broadening her knowledge of practices in the profession as they are expressed by students from all sections of the world.

The field agency, as well as the instructor, gains from having its employee a member of the university faculty. There are open to it through this alliance resources such as library facilities, expert consultant service from many areas of specialization, reports on studies, broadened experience in work with students, and association with other faculty members in nursing and in other professions. One medical director has expressed his approval of such dual appointments since he recognizes that an agency is thereby permitted to secure and retain better qualified personnel than it could employ if there were not the additional remuneration provided by the university for all personnel who carry an additional teaching assignment. There is the added recognition of the agency through employment of its personnel by the university and the influence this may have in a university community. There is the focus, too, on nursing in its broadest sense and the emphasis that can be placed on this in an agency. There is the sense of making a contribution to the development of nursing in the university. Each member of the agency staff shares in this through her professional representatives. Associated with this is the obligation to make the best kind of representation for one of the younger members of the academic family. The instructor also gains experience in teaching and has an opportunity to test her interest in and aptitude for organized classroom teaching. She secures help in planning subject matter content, methods of presentation, types of class discussion, construction of examinations, and evaluation of her teaching through work with other faculty members. She needs to plan for this just as she works in a field agency in coordination with the administrator. The part-time instructor cannot discharge her obligation just by coming to the university for the class period. She must and would want to be accessible to students for help in meeting assignments, for counseling and for coordinating this course with other subjects in the curriculum. This is all part of the teaching role.

IN THESE days of shortages of professional staff members, the value of such an alliance in terms of recruitment for the agency must not be overlooked. After saying that, I can envision a rush of public health nursing administrators storming the doors of the universities in search of such an affiliation.

Before you hurry too rapidly, let me say again that although this combination is near perfect for the instructor, there are certain limits which affect each phase of the job. It is not possible on limited time to participate in all aspects of the university program. That demands full-time personnel. It is necessary to remain outside of certain areas and to have what may seem at times like an incomplete picture. There is need also to guard against reducing service needed in the field agency. Fixed class schedules have a way of demanding one's presence. The agency staff makes a significant contribution to the teaching program and cannot maintain good service unless given adequate assistance. Actual division of time presents problems but not ones that are insoluble. Planning with the administrators of each program can be effective in meeting this. Few people find sufficient time for planning. This is emphasized for the part-time person, but a way must be made to provide a reasonable amount of time for planning activities in each area of the job.

The combined assignment is rich with opportunity for a vital experience for instructor, student, agency, and university if we recognize the way to reduce as far as possible the difficulties that may be inherent and make the most of the advantages.

INITIATING NEW COMMUNITY HEALTH PROGRAMS

BOSSE B. RANDLE, R.N.

THE UNIQUE function of the public health nurse in relation to the established preventive and control programs within the health department has been described many times. Her role on the health team in planning the development of new health programs and changes in existing ones is less frequently emphasized but it is one of her recognized responsibilities. When the public health nurse is given status and freedom for creative thinking and action she makes her greatest contribution to the forward movement of the team and to the health of the community.

When the Nassau County Department of Health was established in 1938, two registered nurses were employed by the tuberculosis sanatorium for the follow up of 1600 or more registered cases of tuberculosis. As the health department assumed responsibility for the community control aspects of the disease it was imperative that nursing follow up be included. The medical director of the sanatorium was none too sure of the wisdom of relinquishing this responsibility to a group of public health nurses who were unknown to him, and whose preparation and experience in tuberculosis work were questionable to him. The health commissioner guessed that forcing the issue would only increase the barriers. The newly appointed director of public health nursing knew from a review of the preparation and experience of each nurse that education in tuberculosis nursing control measures was needed by the entire nursing staff. Therefore the commissioner and the director decided to ask the medical director of the sanatorium and the Tuberculosis and Public Health Association, which also employed a nurse, to assist in planning a unit of instruction to prepare the nursing staff for participation in tuberculosis nursing. The nursing director made the request. The medical director of the sanatorium carefully planned and gave a series of 16 lectures enriched by case histories, plates, and slides. By the last lecture, all the public health nurses had been adopted by him as a part of the tuberculosis team. The rest was easy. After a period of observation in the out-patient clinic and on the wards, all cases (summarized by the incumbent nurses) were gradually turned over to the public health nurses for follow up under close supervision.

When cancer was made reportable in 1940, and new data on cancer prevalence began to accumulate in the department files, the individual needs behind recorded diagnoses seemed all too clear. Both the commissioner and the nursing director saw the need for nursing follow up as a part of the general public health program. At the time a registered nurse was employed by the Nassau County Cancer Committee to give nursing care to terminal cases in the home. Mandatory re-

Miss Randle is director of the Division of Public Health Nursing, Nassau County Department of Health, Mineola, New York.

porting heightened the interest of this committee in cancer and led to its consideration of the appointment of a second nurse. The commissioner knew as did the director of nursing that the fear of being absorbed which characterizes many voluntary agencies, especially where nursing is concerned, was great enough, so that it was not good policy to approach the committee with the direct suggestion that the health department assume responsibility for the nursing aspects of the cancer program. They decided it would be a good idea for nursing to carry the ball but to make an indirect approach. The cancer committee, an integral part of the County Medical Society, was housed in the society office. A planned visit was made to the executive secretary of the society by the nursing director to discuss general progress in public health nursing and repeat the offer of public health nurse assistance to private physicians. Minute details of the steps in the transfer of tuberculosis nursing from the sanatorium to general public health nursing the year before were described during the discussion. Before the visit was over the executive secretary asked why the same plan could not be followed to meet the need for more cancer nursing service. This original idea was welcomed with surprise and admiration by the nursing director! The suggestion was made that he propose it to the cancer committee board and to the health commissioner which he promptly did. The transfer of cancer nursing to the health department was accomplished within a year.

Each person is selected for the public health team by reason of the special skills he possesses which are needed to do the total community health job. Each in turn must initiate certain activities essential to the successful application of his skills about which only he is familiar. For example, in 1938 the nursing director, recognizing the need for the coordination of all nursing services and sensitive to the fears mentioned above, brought together with the help of the chairman of the board of health and the commissioner, the board members and nurses from the ten small visiting nurse agencies in the county. The immediate purpose of the joint conference, to interpret what service was given in their respective communities and to help plan for the best placement of health department staff in relation to their services, accomplished the desired end. This was the establishment of a public health nursing council which has continued in the interest of improving the public health nursing services and studying health needs of the entire community. Among the outstanding contributions this council has made to the public health program in the county are the enlistments of its agency members as key groups for planning and carrying out special public health projects such as mass x-ray surveys and smallpox and diphtheria immunization programs; integration of voluntary and official public health nursing services in four communities; and stimulation toward the formation of a county council of health organizations. Recently when official efforts had failed to awaken interest among hospital authorities in referrals for nursing follow up, the annual council luncheon featured Dr. Martin Cherkasky, director of the home care program of Montefiore Hospital, New York City, as the guest speaker. A number of hospital board members, chiefs of staff, administrators and superintendents of nurses attended in response to special invitations. Subsequently the council's executive board appointed a committee to study the home care problem and to suggest a plan of approach aimed to secure hospital participation during the coming year.

LESS THAN two years ago Levittown, a large housing development, was born in Nassau County. During the first month 1,000 new homes were occupied by ex-G.I. families; today there are 7,000 homes with approximately 25,000 people. Almost immediately nurses working in the area began to sense the great emotional, social and economic stress and strain among these young families. Individual incidents where health and medical needs were not met, were regularly referred by memorandum to the deputy commissioner. The large number of expectant mothers and no place to hold mothers' classes, infants without medical supervision and preventive treatments, the lack of transportation to tuberculosis clinics

and other county health facilities were referred by memorandum many times over. Collectively these bits of information from the nurses eventually spelled out an acute need for health facilities to both the deputy and the commissioner. Yet, because of many factors known to them, county authorization for such a project could not be secured through a direct approach to the county executive. Together the commissioner and the nursing director planned an approach in which the area nurses again were to carry the ball. The nurses were brought together and acquainted with the underlying factors. With their help, careful plans were laid to stimulate community demand without committing the department or the county executive. Thereafter, upon each visit the services of the health department were fully explained. Mothers' classes limited to eight were started in the small homes due to lack of other facilities and later taught in the basement of the community church when it was completed. Nursing care was given as needed. Mothers and new babies were visited with much emphasis on teaching. Fathers' classes were started in the evenings at the Quonset Hut School. "Why can't we have a health center" became a frequent question which the nurses tactfully guided toward other ears. Finally the builders were besieged and the county executive was approached by a large and representative group with a request for a health center to serve the area. The project is now under official consideration. This might be called "indirect" initiation. The nurses' bits of information like a mosaic, took shape to condition the thinking of the commissioner toward an objective. He in turn, when his thinking crystalized into action, made a plan with the nurses which conditioned the thinking of the people to make a direct request to the county executive.

There have been many other projects initiated by the public health nurses. Time does not permit to describe in detail how clinics have been opened and closed upon the area nurses' observation and presentation of supporting data, how infant and preschool clinic records came to be summarized and sent to the schools as the preschoolers entered for the first time; and how the area nurse came up with the answer or information on which a decision by the health commissioner depended.

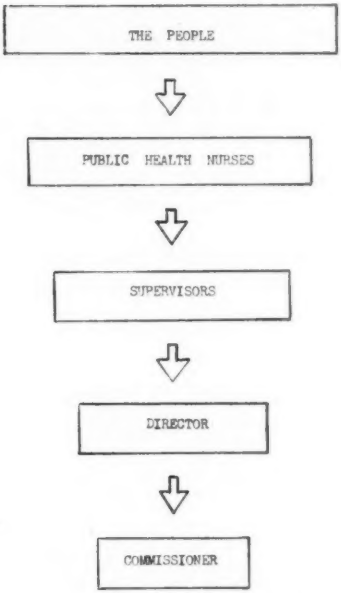
ALTHOUGH THE examples I have cited were taken from a large county health department their counterparts may be found in other health departments regardless of size of staff.

These contributions of the nurse are not accidental; they do not just happen. Just as the soil is so essential in determining the kind of fruit a tree will bear, the philosophy underlying the organization of the health department and the personal relationships maintained, condition the richness of the nurse's contribution. If day in and day out she has a part in the planning, is taken behind the scenes to learn what makes the community tick, she develops a sensitivity to the forces at work about her and a pride in helping to harness them to the good ends the health official hopes to achieve.

This means simply that the nurse can do her best work when she has status, when her place on the team becomes a reality to her through experience and she is no longer the water boy. What is her place on the team? Perhaps we should begin with a purge of our vocabularies of such words as *using* the nurse, her *superiors,* and the like. On a team no one is truly superior, the game is as good as its weakest player. At some point each person is what we choose to call superior—on him for the moment hangs the game. So it is with the public health team.

There are differences in responsibilities often designated by charts and graphs showing lines of administration. These should not be thought of in terms of ranks and levels, but rather as channels of operation. This kind of thinking is needed to give recognition to the personal dignity of the nurse and other personnel as well as to beget mutual respect where it is deserved. Perhaps the simple diagram (opposite) which we have used in the orientation of new staff to the philosophy of the nursing division will best illustrate this point.

The purpose of the health department is to protect and improve the health of the people of the community through its six basic serv-



ices. The people are, therefore, the most important persons in relation to the health department. The public health nurses together with other field workers such as the epidemiologists and the sanitary inspectors are closest to the people. They do the work that makes or breaks the health program in the community. The supervisor is justifiable only to the extent that she helps the nurse where she needs it; the director only to the extent that she constantly serves the area nurses and supervisors in meeting their problems, in bringing them to program directors and the health officer, and in interpreting their services to the community. The health officer is justifiable only to the extent that he gives the kind of leadership which brings community recognition to and participation in the health program.

It is recognized that this concept of team play is not universally practiced. It is my belief that fear of change is a factor which prevents many health departments from making the application. The idea is easily initiated by a new health department at the start, but it is not difficult for a long established one to adopt it. Just as the medical director of the sanatorium was conditioned to change by a satisfying experience, personnel of any department can likewise find satisfaction through experiences designed to put this concept to a test. The real evaluation lies in unusual benefits provided to the people and in the recognition they give to the community health program.

Presented at the first special session of the 45th Annual Health Conference of New York State, Lake Placid, New York, June 1949.

SOME ADMINISTRATIVE PROCEDURES IN SCHOOL NURSING

DOROTHY E. WIESNER AND MARIE SWANSON, R.N.

FROM THE 1948 NOPHN Yearly Review returned by a representative group of school nursing services in boards of education, we learned something about the provision of services of physicians and nurse supervisors in school health, relationships between boards of education in school health and health departments, lines of responsibility reported by school nurses, and variations as to time spent by school nurses in home visiting.

The 168 replies came from all sections of the country. More than 60 percent of the agencies employed less than 5 nurses, and only 7 percent of the agencies employed 25 or more.

SERVICES OF SCHOOL PHYSICIANS

The questionnaire asked whether the school physician was employed full time or part time, or in some other way. In only 42 places were full-time school physicians found; 73 reported part-time physicians; 12 reported other arrangements for physicians' services; 41 reported no physician, or did not answer the question. Many of the services employing 10 and more nurses reported that both full-time and part-time physicians were employed. Among the part-time medical personnel were ophthalmologists, otologists, and psychiatrists. Dentists were mentioned more frequently than any of these three. The 12 replies that stated other arrangements for medical services all came from school services employing less than 5 nurses. Four of these used the phrase, "physician on call"; 3 said physicians volunteered; 3 that the local health officer served when needed; 1 said the county medical society provided physicians' services. One place reported that the board of health paid private physicians for physical examinations. With such wide variations as to the availability of medical direction, it is not surprising that many nurses did not include the school physician as the member of the school health system to whom they were responsible, or under whose direction they worked.

AVAILABILITY OF A NURSE SUPERVISOR

Although only 30 replies reported any line of responsibility to nurse supervisors, 93 stated that consultation with such a person was available; 70 said it was not; only 5 skipped the question. The school nurse supervision available in these services came from local and state boards of education in 60 instances, local and state health departments in 24, from both boards of education and health departments in 2 and in the other 7, the type of agency employing the supervisor was not clearly mentioned.

Miss Wiesner is statistician and Miss Swanson, assistant director and school nursing consultant, of the National Organization for Public Health Nursing.

*Wiesner, Dorothy E., and Murphy, Margaret M. Relationships of health agencies. PUBLIC HEALTH NURSING, January 1944, vol. 36, p. 39-43, 59.

JOINT PLANNING BY BOARD OF EDUCATION AND HEALTH DEPARTMENT

Although only 11 of these school nursing groups included health officers as persons to whom they were responsible, more than 100 stated that there was provision for joint planning with the health departments. In 1942 a list was published to show plans reported by 149 boards of education for relating the work of their nurses to those in health departments.* From this study, the following data in Table I are available to compare provisions in the year 1942 with those in 1948:

TABLE 1. PROVISIONS FOR RELATING WORK UNDER BOARD OF EDUCATION TO THAT OF THE HEALTH DEPARTMENT.

	1948		1942	
	Number	Percent	Number	Percent
Total in sample	168	100.0	149	100.0
Reporting provision for relating work	97	57.7	83	55.7
Reporting no provision for relating work	51	30.4	30	20.1
Qualified answer	7	4.2	....	.....
No health department in area	....	.....	4	2.7
No reply	13	7.7	32	21.5

The two sets of figures seem to be in agreement that about 60 percent of these representative boards of education health services have some provision for joint planning with the health department—and probably 40 percent do not.

The larger the nursing service, the more likely the provision for joint planning. In the 1948 material, among the boards of education employing less than 15 nurses, only 54 percent reported such joint planning, whereas among those employing 15 and more nurses, 83 percent did so. In both the 1942 and 1948 studies, acute communicable disease and immunization programs were mentioned frequently as needing joint planning.

LINES OF RESPONSIBILITY REPORTED BY SCHOOL NURSES

Almost 100 of the replies stated that the school nurses were responsible to the principals or superintendents of the schools. Some of these stated more than one line of responsibility, including, besides school physicians, directors of health education, of physical education, and of "special interests." Only 30 reported direct responsibility to nursing supervisors. Eleven included local health officers as persons to whom they were responsible. The following list shows some of these lines of responsibilities:

LINES OF RESPONSIBILITY REPORTED BY SCHOOL NURSES

Total in sample	168
Superintendent or principal only	54
Principal and school physician	22
School physician only	20
Nurse director and school physician	10
Nurse director only	9
Principal and health officer	7
Principal and nurse director	6
Health officer only	3
Nurse director and school health director	2
Principal and other	2
Other single lines stated	27*
All other combinations	6

*Some of these stated the nurses were responsible to the boards of education, to supervisors of health education, directors of research, of child development, of physical education and safety, and similar department heads.

TIME SPENT IN HOME VISITING

Another subject of interest to school nurses, and to other public health nurses also, is the home visiting part of school health work. The question: "How many hours of the school week does each nurse usually spend in home visiting?" may seem to call for guesses rather than accurate data, but the tabulated answers

TABLE 2. WEEKLY WORK HOURS AND HOURS PER WEEK USED FOR HOME VISITING

Weekly work hours	Total boards of education in sample	Average hours per week per nurse used for home visiting
Total boards of education	168	8.4
44 hours and more	9	16.8
42-43	2	.....
40-41	40	9.7
38-39	3	8.3
36-37	14	9.6
34-35	43	8.2
32-33	20	5.0
30-31	26	6.9
Less than 30	10	5.8
Not stated	1	.....

proved interesting. Only 3 replies of the 168 said the nurses spent no time in home visiting; and 48 gave data not classifiable numerically, including such replies as "when necessary," "after school hours," "no schedule." The other 117 stated hours per week ranging from 1.5 to 28 hours. Such a wide variation is possible because of the wide variation in total weekly work hours; these figures varied from a low of 25 hours per week to a high of 48. Available figures indicate that school nurses average about 8 hours per week for home visiting. Table 2 shows that this time varies directly with the total number of weekly work hours.

Other kinds of work which necessitated time not accounted for in the school health room were meetings, community talks, accompanying children to clinics and physicians' offices, and supervision of special activities after school hours. "Meetings" were mentioned most frequently. The participation of the nurses in one city in "supervision of special activities" every school day from 3:30 to 5:30 p.m. was noteworthy. School nurses in this city reported a 40-hour week.

WHO FELLOWSHIP PROGRAM

The World Health Organization offers to the United States an allotment for foreign study in the field of health. It is expected that from nine to twelve fellowships will be available in 1950. A Fellowship Selection Board has been set up by Surgeon General Leonard A. Scheele, made up of Dr. Joseph W. Mountin, U. S. Public Health Service; Dr. Hugh Leavell, American Public Health Association; and Dr. Walter A. Bloedorn, Association of American Medical Colleges. Dr. H. R. O'Brien, U. S. Public Health Service is secretary. The Board makes the following announcement:

For 1950, applications will be considered in the fields of public health administration, (especially as given in courses at schools of public health) malaria, tuberculosis, maternal and child health, venereal diseases, sanitation, nutrition, and mental health. Work in clinical or basic medicine or in branches of public health not mentioned here may also be considered if needed for teaching or important service.

Applicants must be engaged in some form of full-time public health work, including medical or nursing education. In evaluating applications the Board will take into account the ability of the individual and the value to his community or his country of the training he will receive abroad. Special consideration will be given to such people as those in charge of training centers or teachers in medical or other schools (especially in Preventive Medicine or Tropical Diseases). An advanced degree, in one's field, or Board certification is desirable. Knowledge of the language of the country to be visited is valuable. In general, non-federal workers will be preferred.

Grants are for periods of from 2 or 3 months, for observation, up to 12 months for study. WHO provides transportation across the ocean and in the country visited, with a stipend of $200 a month for those studying in one place, $300 for those moving about. Application blanks may be obtained from the Educational Programs Branch, Office of International Health Relations, U. S. Public Health Service, Washington, D. C. Applications must be filed in triplicate by March 1, 1950.

THE STAFF NURSE SPEAKS HER MIND ABOUT SUPERVISION

A Report from the Bureau of Public Health Nursing,
New York City Department of Health

UPON THE initiation of the Staff Nurses' Council of the Bureau of Public Health Nursing, New York City Department of Health, and in cooperation with the Supervising Nurses' Council and the central administrative staff of the Bureau, a survey was recently completed by questionnaire of how staff nurses react to the supervision they are getting.

Although at first quite a jolt to the *amour-propre* of some of us in supervisory and administrative positions who consider perhaps that we might have diplomatic immunity from any looking into what we believe to be our daily duty with respect to staff nurses, we soon saw definite advantages in the idea. First, seeing ourselves as our coworkers see us is good for any soul. Then, too, this offered a specific opportunity to practice the democratic administration to which we so freely give lip service. Most important of all, the public health nursing service stood only to gain in the way of improvement, through this extra insight afforded its administrators and supervisors into so significant a phase of their responsibility.

Questionnaires cooperatively devised by a committee of the Staff Nurses' Council with Helen Moos as chairman, a committee of the Supervisor's Council with Borie Toth as chairman, and the Bureau of Public Health Nursing were distributed in February 1949 by the Bureau via the district supervising nurses to every nurse on the staff, then a total of 786.

The completed questionnaires were collected by the staff council delegate, sent to the committee of the Staff Nurses' Council and finally to the Bureau, where they were tabulated and summarized. No names appeared on the questionnaires. In all, 566 questionnaires, about 72 percent of those distributed, came back—a good yield considering that the project was entirely voluntary, the idea quite an unfamiliar one, and a considerable proportion of the staff at the time comprised new nurses who had not been in the Bureau or, for that matter, in public health nursing long enough to wish to venture an opinion on supervision.

The percentages of the 566 public health nurses who completed the questionnaire by their length of time in service were approximately as follows:

Length of time in service	Percent
Less than 1 year	18
1 to 3 years	20
3 to 5 years	10
5 years or more	49
Not reported	3
Total	100

Twenty percent of the questionnaires came back with comments additional to the answers to the scheduled questions. The nurses in service under 5 years offered proportionately more comment (24 percent) than those in service 5 years or longer (17 percent).

The schedule or questionnaire was divided into 3 units. The questions are presented here together with the percent of "yes" and "no" answers to each.

In Unit A, the most "nos" significantly enough came in response to questions 1(a), 1(b), and 3. With respect to 3, the fact that approximately 23 percent of the respondents should find staff conferences not stimulating

or interesting is certainly less than flattering to supervisors.

It seemed that those in service 5 years or longer were more frequently bored (28 percent) than those in from 1 to 2 years (18 percent). Draw your own conclusions!

The questions that yielded the largest number of affirmative replies in Unit B of the schedule were items 3 and 6—about 81 percent each—heartening on the technical side of supervision!

The most "nos" came in response to item 11, an area which one would imagine would lend itself most easily to administrative clarity.

It would seem from the fact that questions 9 and 10 were asked at all, that staff nurses feel they should be able to depend on supervisors keeping them in touch with local and national professional activities and to give them general educational support and guidance as well as technical assistance, particularly in so large an agency as the one in question. However, nearly a fourth of the staff nurses (24 percent) answered "no" to both questions dealing with these matters.

Public health nurses in service 6 months or less seem to miss the sharing of the supervisor's "professional knowledge of current trends" less (19 percent) than those in service a year or longer (24 percent).

The three questions which produced the most "yes" answers in Unit C are 5(b), 9(a), and 9(b).

Throughout Unit C, the number of persons giving an unequivocal "no" answer was relatively small. Items 5(a) and 7(a) in Unit C brought 41 percent and 52 percent of noncommittal replies. Perhaps a "yes" answer to "does your supervisor make you feel you are working for her" (instead of the service) and "does she maintain a dictatorial attitude" seemed to staff nurses improperly critical of their supervisors!

That nearly 26 percent of those replying should believe or at least *say* that their supervisor did not "recognize and help develop the potentialities of each worker" bears some serious reflection on the part of all supervisors and administrators.

And now what about the gratuitous comment which is likely to be the most exciting and revealing part of any inquiry. The content of the remarks contributed by staff nurses in addition to their replies to the questionnaire does not lend itself readily to classification or summary. However, in general, by type of comment, they can be classified as follows:

Explanations of replies	29 percent
Unfavorable criticism	26 "
Favorable criticism	24 "

UNIT A

Questions	Answers: Percent "Yes"	Answers: Percent "No"	Answers: No Answer
Staff conferences			
1. (a) Has discussion been held by the supervisor with the staff regarding the educational plans and policies for staff conferences of the Bureau of Public Health Nursing?	74.7	20.5	4.8
(b) Are you encouraged to request staff conferences, the content of which may fit the specific and immediate needs of the community problems as you see them?	70.1	24.6	5.3
2. Are you encouraged to give constructive suggestions to make conferences more vital and interesting?	81.6	15.6	2.8
3. Do you feel that staff conferences are stimulating and interesting?	72.8	22.6	4.6
4. Are you encouraged to participate in discussions during staff conferences?	87.8	9.7	2.5
5. Would occasional group discussion at the end of a staff conference be of value for determining the practical and educational merits of the conference?	87.8	7.6	4.6

UNIT B

Questions	Answers: Percent "Yes"	Answers: Percent "No"	Answers: No Answer
In the interest of good family health service does your supervisor			
1. Stimulate your initiative within the scope of staff nurse responsibility?	78.4	17.3	4.3
2. Give you constructive help in solving special individual problems?	78.6	17.1	4.3
3. Encourage you in bringing your (work) problems to her?	80.9	14.8	4.3
4. Stimulate you to maintain initiative in the specific work situation—home, clinic and school?	77.0	18.9	4.1
5. Make practical, helpful suggestions for improving your work?	74.9	19.8	5.3
6. Help you understand the principles, reasons, and uses for good record keeping?	81.1	13.4	5.5
7. Seem to provide for an equitable service load?	69.4	19.1	11.5
8. Plan an individual conference following her observations of your work in field, school, clinic or other location?	72.1	21.9	6.0
9. Share with the staff her professional knowledge of current trends in the community, state, and nation as a whole?	71.7	23.9	4.4
10. Motivate you to seek out sources of information relative to your professional and cultural education and progress?	71.9	23.7	4.4
11. Inform the staff as to policies governing the selection of personnel for special assignments such as special clinics, emergency service, night duty?	60.4	32.9	6.7

Suggestions for improving preparation of staff or supervisory-staff relations ..... 16 "
Miscellaneous other comment ..... 5 "

On the positive side, comments from staff nurses included these:

Her (supervisor's) attitude makes you want to do your best.

My supervisor has helped me grow as a person and in my job . . . she treats us as individuals and respects our individual ideas.

Assistance (by supervisor) is given in a pleasant impartial manner which stimulates respect and cooperation in the (staff) nurse. One feels encouraged to ask her aid . . . due to her willingness, fairness and ability . . .

It is a pleasure to have a democratic and understanding supervisor. It makes for better service . . .

If all supervision were as democratic, understanding and constructive as that given in my unit the Department would not suffer from demoralization and inferior services and attitudes.

On the negative side:

Too much concern about a certain few.

In this district (the supervising nurse) in exercising her autocratic methods has made most of the nurses feel that they are doing the job for her benefit, not for the city . . . upon leaving meetings we feel that we have been treated like ungraded pupils in an ungraded class.

The supervisor is too often apt to make the younger nurses feel superfluous.

The stress laid on youth has become quite painful to many of us who feel that we have many years of active, constructive work ahead. . . . At present we are made to feel that we need special "reactivation to perform the simplest duties."

Supervision for the most part consists of orders and fault finding.

And now, in conclusion, a general comment

UNIT C

Questions	Answers: Percent "Yes"	Answers: Percent "No"	Answers: No Answer
From the standpoint of individual growth and development of staff, does your supervisor			
1. Respect the personality of each worker?	74.7	10.3	6.0
2. Recognize and help develop the potentialities of each?	64.3	25.8	9.9
3. Help with personal problems upon your request?	79.9	9.9	10.2
4. Act impartially?	74.2	18.4	7.4
5. Make you feel that you are working for (a) her	9.0	39.4	51.6
(b) the service	84.8	4.6	10.6
6. Criticize your work before others?	10.6	84.3	5.1
7. Maintain a (a) dictatorial attitude	16.2	42.8	41.0
(b) democratic attitude	75.1	10.2	14.7
8. Exercise authority in a way to antagonize?	20.7	72.3	7.0
9. (a) Afford opportunity for individual conferences?	80.2	10.2	9.6
(b) Provide privacy for such conferences?	82.3	6.2	11.5
10. Give you the guidance and assistance you want and need?	77.0	17.9	5.1
11. Stimulate a sense of responsibility toward staff associates and the agency?	75.1	17.9	7.0
12. Stimulate mutual give and take for the benefit of the nurse's professional and personal development?	71.4	20.8	7.8

in a plaintive, admonitory vein from a young public health nurse:

> . . . I know that I should be very unhappy in my work and probably would not continue with it if I thought my supervisor was not capable. Nursing is filled with women of the dictatorial rather than supervisory quality and there is no room in public health nursing for women of that type. Many of us left the hospital field for just that reason. Let us choose supervisors by their ability to work with people rather than over them and do away with those who are "high on the list" but don't know how to be human.

The reader will quickly realize from the kinds of questions that staff nurses, through their council, wished to ask, that getting these off their chests was a most important motive behind this staff project.

The answers obviously do not lend themselves, nor were they meant to, to scientific statistical compilation or conclusions about supervisory practice.

But to the sensitive administrator to whose attention dissatisfaction with supervision, well founded or not, is continually brought by individual staff nurses or through their staff organizations, the response to a questionnaire of their own designing cannot fail to serve as a barometer of staff morale. For the supervisors themselves—young or old in the service, with variations in preparation and experience, reactions thus expressed cannot fail to be similarly revealing.

And for the most important person of all, the public health nurse, who gives direct service, an outlet for expressing herself through her own questions and answers about what she thinks of supervision cannot help but contribute to her professional development as well as give some release to her frustrations.

It is for these three reasons that we believe joint staff, supervisory, and administrative projects of this kind have value.

TRENDS IN MEDICINE AND PUBLIC HEALTH

WHO TUBERCULOSIS PROGRAM FOR 1950

A series of measures designed to strengthen health administrations in undeveloped countries in the fight against tuberculosis have been drawn up by the Expert Committee on Tuberculosis of the World Health Organization. These and other recommendations will be passed on by the Executive Board of WHO in January. The measures will then be fitted into overall plans that are being carried out by WHO to combat tuberculosis.

Effective control schemes in undeveloped countries, the experts agreed, must start with a survey of needs, resources, and attitudes of the people. This preliminary work done, a central group directed by a leader can proceed, devoting much of its time to the training of personnel for field work in the country as the program develops.

The experts pointed out that WHO could give valuable service in setting up centers to train local personnel in tuberculosis control and to serve as demonstration centers for medical and auxiliary personnel in the area. WHO could also advise on setting up hospitals rapidly and economically.

Health education was recognized by the committee as an essential tool in tuberculosis control. It was urged that WHO encourage national and international voluntary organizations to inform the public on all aspects of the tuberculosis program carried out in a particular country in order to secure active support for it. Where such voluntary associations do not exist, the expert committee recommended that WHO through its field staff promote their development and affiliation with the International Union against Tuberculosis.

The value of tuberculin-testing and of BCG vaccination as the only practical way so far of producing specific resistance against tuberculosis was reaffirmed by the committee. It was further emphasized that BCG immunization could be fully effective only if used as part of a general program in addition to other preventive measures. Mass vaccination with BCG was especially recommended for countries with high tuberculosis infection and mortality rates. However, it was pointed out that in all countries vaccination should be applied to individuals and groups for whom exposure to tuberculosis is likely.

Evaluation of results of the mass tuberculin-testing and BCG vaccination now being carried out by the United Nations International Children's Emergency Fund, the Scandinavian Red Cross, and WHO (PHN, December 1948, page 595) is expected to be of great value in relation to future planning of anti-tuberculosis campaigns.

The question of streptomycin is to be taken up by the International Union Against Tuberculosis next year. In the meantime the experts urged caution in its use on the grounds that the drug is dangerous and many questions in regard to it need full answer.

The Expert Committee on Tuberculosis is only one of the international groups which are to map details on plans adopted by WHO in Rome in June 1949 for implementation in 1950 against numerous priority disease problems. The meeting on tuberculosis will be followed in months to come by gatherings of experts on malaria, venereal diseases, maternal and child health, mental health, and others.

NURSING CARE FOR THE TUBERCULOUS

The need for providing effective nursing care to patients in tuberculosis hospitals was discussed at the joint annual meeting of State Tuberculosis Control Officers and State Tuberculosis Sanatoria and Hospital Directors in Detroit in May 1949. Some of the facts regarding this problem are reported by Chesley Bush, Esta H. McNett, Lucile Petry, and Martha B. Naylor in *Public Health Reports*, August 5, 1949. Concrete suggestions are made for increasing the number of nurses for

tuberculosis nursing services in the United States. For example, it was pointed out that nurses will be attracted to positions in hospitals where the doctors make them important members of the medical team. Some other positive steps which were suggested are improved precautionary measures to protect the health of the personnel, better instruction of nurses and auxiliary workers, better personnel practices including hours of work, salary adjustments, recreational and transportation facilities, adequate housing, increased employment of minority groups, job analyses, and better utilization of time.

The supply of nurses in the tuberculosis field has greatly increased in the past few years. However, the demand has exceeded the supply. The article concludes: "If our society can provide enough nurses to staff its hospitals adequately, each nurse will do her utmost to give the kind of patient care for which she has dedicated herself to her profession."

TELEVISION AND EYESIGHT

Watching television may cause people to receive needed eye care more promptly, according to Dr. Benjamin Rones, in the *Sight-Saving Review*.

Every ophthalmologist has complaints that after watching a television program for an evening, the patient, or his children, complain loudly and frequently about pain in the eyes, says Dr. Rones. The frequency of these complaints justifies examining the contributing factors to see if they cannot be minimized and greater ocular comfort achieved. The clarity of the image on the screen is of primary importance. Stations should only be tuned in that afford a powerful enough signal to give a clear-cut image. Others are indistinct, "grainy," and conducive to ocular fatigue.

The illumination of the room should not afford too great a contrast between the background and the screen. With the proper daylight screens it is not necessary to keep the room dark in order to obtain a clear image on the screen. The constant shifting of the eye from a bright to a dark background causes work for the pupil-regulating musculature.

If the instrument is to be placed in a large room and used to entertain the children and their friends, then a large screen is desirable. However, if only two or three people expect to view it in a smaller room, then a smaller screen is satisfactory. No matter what size screen is used, it is not necessary for the person with good vision to get very close to the instrument; and if this is the only way he can see the image, then it is wise for him to have his eyes examined, for he is not seeing properly. It is also more comfortable to view the screen from directly in front, for there is considerable distortion when the angle of observation is too great.

If it is necessary to spend a prolonged time in watching a television screen, it is advisable to break the fixation by shifting the gaze away from the screen at fairly frequent intervals.

Dr. Rones concludes, "It may eventuate that the fatigue induced by television may be a sight conservation boon, for it will cause the individual to seek medical attention earlier and, in a number of cases, allow serious eye diseases to be discovered at a more favorable time than would otherwise be the case."

ACCIDENTS IN THE HOME

An accident is a chance event, developing without foresight or expectation and resulting in injury or loss. This broad interpretation must be narrowed when accidents are considered as a health problem of groups of people, because the episode may relate to a person or a thing, to an injury or a material loss, serious or slight. Dr. John E. Gordon, in charge of Preventive Medicine and Epidemiology at Harvard, in the *American Journal of the Medical Sciences*, March 1949, has supplied an analysis of accidents, general as well as home, and offers suggestions for prevention.

In 1947, some 99,579 deaths in the United States were the result of accidents, a mortality rate of 69.4 per 100,000 population, of which over one third were home accident deaths. Accidents are the fourth cause of death in the United States; separately, home accidents rank ninth.

An evaluation of any community or mass disease on the basis of deaths is not the method of choice, for judgment is more satisfactory when the number of events that occur can be

counted. With accidents and with many of the more important diseases, cases are not uniformly collected and made a matter of record. The temporary disability associated with a disease condition may be a far more important health consideration than the deaths that occur. Lacking complete information by which to judge the losses from defect and disability, an approximation can be had by local surveys of fatal and non-fatal events. The National Safety Council published estimates for 1947 based on various established sources. Of all deaths from accidents among the civilian population of the U. S. in 1947, 35 percent were due to injuries sustained in the home. Of non-fatal accidental injuries, one-half a total of 10,520,000 were due to home accidents. For every death, 150 others were temporarily disabled, and 4 suffered permanent impairment. Direct costs were incredibly high—estimated at $7,100,000,000.

There is clearly a need for a more energetic and reasoned advance on the health problem inherent in home accidents. If home accidents are a primary responsibility of community medicine, then it is reasonable to apply the technics upon which all community health practice is based. This includes an initial epidemiological analysis followed by a focal attack on places and toward situations where accidents have been most pronounced.

The most common fatal home accident is from falls, approximately one-half of all fatalities. Falls on the same level outnumbered falls from one level to another in the proportion of 3 to 2, and together were responsible for more than three times as many deaths in 1947 as the second most frequent fatal home accident—burns, scalds, and explosions. Death from mechanical suffocation ranked third despite its limitation to infants under one year of age. Poisons (except gas), poisonous gas, and firearms rank fourth, fifth and sixth, respectively. These six types were responsible for some 85 percent of the 34,000 accidental deaths in homes during 1947.

The accepted classification of home accidents by types gives too little information about cause and/or detail of activity in which the person was engaged at the time of the accident, and of the mechanisms by which the accident took place. The recognition of the cause is of practical consideration in understanding and preventing home accidents.

It is a common tendency to look upon a person who suffers an accidental injury as the victim of circumstances, and yet the explanation of home accidents is believed to be more frequently found in "host factors" within people themselves than in either environment or agents directly concerned. Some people are usually susceptible to accidents.

Deaths from home accidents are more frequent in the extremes of life. Death rates for infants are commonly 3 and 4 times greater than for older preschool children. In 1945, for all children under 5 the home accident rate was 42.2, while for persons 65 and over it was 185.0 per 100,000. Men and boys suffer more home accidents than do women and girls. Individual types of accidents show pronounced differences: falls were not represented in the youngest age group but assumed increasing importance with advancing age, becoming the leading cause at 45 years and thereafter. Accidents from cutting and piercing instruments affected principally children and young adults. Burns were the principal accidents to children under 14, and remained among the first four in all other groups. Mechanical suffocation ranked second and third in the preschool age group, while firearms were the chief cause of accidental injury among boys in the 15 to 24 age group.

Causation of accidents needs to be explained, not in the limited sense of the direct agent, but through consideration of the multiple factors inherent in the host, the agent, and the environment. The principal instruments of a preventive program are public health education, demonstration of existing accident hazards in the home, and direct instruction in the means by which they can be corrected. So much is said about what may be done by governmental agencies and health departments, while the greatest potential promise of accomplishment in accident prevention is through the private practitioner in his contact with the families of his community. No assumption is made that all accidents can be prevented, but much can be accomplished in decreasing the health losses from that cause.

NEW BOOKS
AND OTHER PUBLICATIONS

SOCIAL MEDICINE—ITS DERIVATIONS AND OBJECTIVES

Edited by Iago Galdston. New York, The Commonwealth Fund, 1949. 294 p. $2.75.

To commemorate the one hundreth anniversary of the founding of the New York Academy of Medicine, an Institute on Social Medicine was organized and 26 outstanding, clear-thinking men from many disciplines and many parts of the world were brought together to discuss the future of medicine and social medicine. This book is the result of the discussions and presentations at the Institute

The book is organized in seven sections dealing with the History, Philosophy and Epidemiology of Social Medicine, Nutrition and Social Medicine, Psychiatry and Social Medicine, Social Applications of Psychiatry, and Social Medicine—The Appeal of the Common Man. The editor, Dr. Galdston, accomplishes the near impossible by weaving the twenty-six essays into a coordinated dissertation with uniformity of style and continuity of thought.

The basic thought of the discussion is not new, having been outlined by Wycliff Rose and Dr. William Welch thirty-four years ago, in their 1915 report to the Rockefeller Foundation, e.g. "Social Medicine rooted in both clinical and preventive medicine and drawing upon the social sciences and on individual and mass psychology endeavors to integrate all of these and yet to remain a distinctive discipline."

The ideas expressed in this small book should be read, studied, analyzed and applied by everyone interested in current and future problems of medicine. This volume should be command reading for both the ardent proponents and the opponents of so-called "socialized medicine" in the United States. Although the book does not deal in any sense with the topic of "socialized medicine," the intellectual approach—as compared with the more common emotional approach—offers many potent suggestions for the solution of the problems of preventive and clinical medicine, public health and medical care, through better analysis, closer integration of the many disciplines which impinge on the problem, and accomplishment through thoughtful evolution rather than legislative revolution.

Each of the essays in itself is excellent and provides many ideas, but on the whole it seems that those by the English authors penetrate deeper into the subject, reveal a more fundamental understanding and are less concerned with the trivial manifestations than those by our own American contributors. The essay on "Social Pathology" by John A. Ryle, Professor of Social Medicine at Oxford, seemed to this reviewer to be the most outstanding in this collection of remarkable papers.

—H. D. Chope, *M.D., Dr.P.H., Redwood City, California.*

MODERN TRENDS IN PUBLIC HEALTH

Edited by Arthur Massey. New York, Paul B. Hoeber, Inc., 1949. 581 p. $12.50.

This is a compendium of recent developments in the field of public health practice in Great Britain. It represents the collection of twenty-three contributions by distinguished men of health. Emphasis is placed upon the newer trends in social medicine and the unique studies which are underway at the Peckham Health Center and also the Health Club at Brandon Woods.

To one steeped in the traditions and progress of preventive medicine in the United States, it seems that much which is now incorporated in social medicine in England has already existed to a varying extent under

the caption of public health practice and public health economics in the United States. The changing social order, however, as developed by Crew of Edinburgh University, delineates historically between medical policy, public health, and social medicine. He states that these represent three variants of one and the same discipline and, of course, with this we are in accord. One frequently is confused with changing trends and emphases in terminology but is impressed with the straightforwardness with which the contributing authors have outlined the progress of epidemiology, health education, public health administration, and the other categories of modern public health service in terms of English experience.

One is impressed that the authors have not taken full advantage of some of the more recent developments in the United States, as, for example, the topical application of fluorine for the prevention of dental caries. But, all in all, the contribution is noteworthy. It recounts many of the milestones in the progress of public health work in England from which, in fact, American practice received its impetus. The book is very much worth while and will fill a definite need for the student of public health practice who is interested in what his English cousin has been doing and what he plans for the future.

—HENRY F. VAUGHAN, *Dean, University of Michigan, School of Public Health, Ann Arbor, Michigan.*

OFFICE MANAGEMENT FOR HEALTH WORKERS

By Frances King and Louis L. Feldman. New York, The Commonwealth Fund, 1949. 164 p. $2.25.

The professional person who either accepts an administrative job for the first time or holds one of long standing will find this small concise book packed with practical down to earth "know-how." Subheadings of the chapter on The Office Staff include, Getting the Work Done, Initiating the Newcomer, Dissensions, Dictating, and Responsibilities of Stenographers and Typists.

Chapter two on The Office Itself gives the reader a clear-cut plan for going about the business of selecting space and setting up an office complete with usable equipment from storage cabinets and shelving to "a handy time saver,"—the slide rule.

Succeeding chapters, such as Your Servant the Record, Correspondence Files, Record Forms and Their Construction, Written Reports, Meetings of the Board, are unique for their recognition of the human equation in the mechanics and technics of operation.

The book provides much needed source material for supervisors and administrators in public health and is a valuable text for use in the training of workers in public health administration. The concept of office management and the philosophy underlying the entire content should attract those in other social and welfare fields.

—BOSSE B. RANDLE, *Director, Division of Public Health Nursing, Nassau County Department of Health, Mineola, N. Y.*

PUBLIC HEALTH IN THE WORLD TODAY

Edited by James Stevens Simmons. Massachusetts, Harvard University Press, 1949. 332 p. $5.00.

This is a collection of unrelated addresses given by a series of guest lecturers before a weekly forum at the Harvard School of Public Health during the academic year 1947-1948. The 22 lectures have been grouped under headings of The Profession of Public Health, Public Health in the United States Today, Public Health Programs and Problems Abroad, and Public Health in a New Era. They cover a wide variety of topics not too well defined by the above headings and ranging from mere descriptions of certain federal (but no state or local) agencies to a discussion of New Public Health Problems of the Atomic Era. Most of the essays are of excellent quality, but there is the usual unevenness characteristic of a book of this type. One gathers the impression that the selection was on the basis of the speaker rather than on subject matter.

The cover jacket claims that "this book presents an up-to-the-minute symposium of what is being done, thought and planned for community, national, and world health—an invaluable and stimulating survey of the whole field." The reviewer can hardly agree that this is a comprehensive survey of either

practices or problems of public health. It is an excellent picture of a few of the fields, but the reader unacquainted with public health would certainly obtain a confused and distorted picture. He might wonder at five chapters on national health agencies yet nothing about state or local public health programs. He might wonder at the omission of a chapter on mental hygiene aside from references to it in the very excellent chapters on the Veterans Administration and on Child Health. The reader might equally wonder that from beginning to end there is no reference to public health nursing, although about 40 percent of the budget of local health agencies is devoted to the nursing program. In spite of the jacket and the title the volume most certainly does not present a comprehensive picture of public health.

If the reader will accept the book with these limitations and will look upon it as a true collection of 22 unrelated papers on certain aspects of public health, he will find in it a gold mine of authentic information. Especially noteworthy is a chapter on industrial hygiene by Alice Hamilton and one on the role of the practicing physician by Hugh Morgan. A real service has been done in bringing this information together in convenient and readable form.

—GAYLORD W. ANDERSON, *M.D., Mayo Professor and Director, School of Public Health, University of Minnesota.*

THE PREMATURE INFANT

By Julius H. Hess and Evelyn C. Lundeen. Second Edition. Philadelphia, J. B. Lippincott, 1949. 381 p. $6.00.

As was expected, the authors in their second edition of this well known text book have again emphasized the individual infant and the care commensurate to his degree of prematurity.

No eventuality is left to chance but total care is discussed in minute detail with the underlying principles fully explained. Numerous illustrations aid in visualizing the technics under discussion. The section dealing with medical therapeutic agents is entirely new and adds much to the completeness of the book.

The chapter on "Home Care" has been enlarged and is comprehensive in detail. However, the psychological effect of having a premature infant in the family has been submerged in the authors' intense concern in the physical care of the infant.

With increasing public interest in the overall problem presented by premature births, the book is not only an excellent text or reference book for institutional nurses but should prove to be of equal value to the public health nurse.

—ELGIE M. WALLINGER, *Director of Nursing, The Children's Hospital, Columbus, Ohio.*

PRESENT CONCEPTS OF REHABILITATION IN TUBERCULOSIS

By Norvin C. Kiefer. New York, National Tuberculosis Association, 1948. 398 p. $3.50.

In order to thoroughly familiarize himself with the background of rehabilitation in tuberculosis, the author read and abstracted over one thousand articles on this subject written between 1938-1947. These were separated into fourteen main topics and were then adroitly arranged into chapters on history, agencies, types of programs, the persistent positive sputum patient, personnel, psychological aspects, and others. A complete bibliography of this literature is included, as is a well organized index for further easy reference to selected passages.

The author limits his own remarks to the last chapter in which he presents the "Future Rehabilitation Program." He regrets the dearth of literature on spiritual assistance as a part in tuberculosis rehabilitation, stating that "on few occasions in life does man seek solace from his religious beliefs as much as during severe illness" such as tuberculosis.

—HELEN HORKAVI, *Tuberculosis Nursing Consultant, Arizona State Department of Health, Phoenix.*

LOVE AND MARRIAGE

By F. Alexander Magoun. New York, Harper and Brothers, 1949. 369 p. $4.00.

At long last, scientists are analyzing the emotional aspects of the marital relationship

in an attempt to help those planning to marry and those already married.

With great detail and clear expression, the author outlines the essentials for a good marriage. In describing what people must bring to marriage so that husband and wife can receive the most from marriage, the author emphasizes the factor of emotional maturity. But, he maintains, emotional maturity is rare. This fact is a great source of marital difficulty.

Throughout the book there is subtle, underlying moralizing, and the reader has the impression that the author is finding fault and blaming those who are not mature enough but who have married. We question, therefore, whether the book written as it is, "as an attempt to give some answers though they can be no more than intellectual," may not cause anxiety and disturbance to those lay people who look to books for the answers to their problems.

As a source book for professional men and women interested in or actively working with these problems, this book furnishes excellent material.

—Dr. Lena Levine, *15 W. 11th Street, New York.*

EDUCATION

Wanted: 30,000 Instructors for Community Colleges. Prepared by the Conference Committee on the Preparation of Instructors for Junior Colleges and Technical Institutes. 51 p. 1949. $1.00.

The following are available from The American Council on Education, 744 Jackson Place, Washington, D. C.

Exploring Individual Differences. Report of the 1947 Invitational Conference on Testing Problems. 110 p. 1948. $1.50.

Improving the National Leadership for Teacher Education. A Report of the Committee on Teacher Education of the American Council on Education. By Laurence D. Haskew. 20 p. 1949. 50c.

Education for the Preservation of Democracy. A Report of the Thirteenth Educational Conference, N.Y.C., October 28 and 29, 1948. 112 p. 1949. $1.50.

Relationships of Education and the Federal Government. Edited by Francis J. Brown. 25 p. 1949. 30c.

Some Current Issues in Education. Edited by Francis J. Brown and J. Roland Kufus. 22 p. July 1949. 30c.

Intergroup Relations in Teaching Materials. Report of the Committee on the Study of Teaching Materials in Intergroup Relations. Washington, D.C., American Council on Education. 1949. 231 p. $3.00.

The Teacher as Counselor. By Donald J. Shank, et al. 48 p. 1948. 75c.

Graduate Training for Educational Personnel Work. By Corinne LaBarre. 54 p. 1948. $1.00.

On Getting Into College. A Study of Discrimination in College Admissions. 99 p. 1949. $1.00.

State Councils on Teacher Education. Prepared by the 1948 Work-Conference on State Councils on Teacher Education. 71 p. 1949. 75c.

The Educational Clinic. By L. D. Haskew. 51 p. 1949. $1.00.

Goals for Higher Education in the Pacific Coast States. The Report of a Conference Sponsored by the Pacific Coast Committee, July 1-3, 1948. 22 p. September 1948. 30c.

FILMS

Planning Films for Schools. The Final Report of the Commission on Motion Pictures. American Council on Education, 744 Jackson Place, Washington 6, D.C. 1949. 34 p. 50c.

RURAL HEALTH

Cooperation for Rural Health. By Helen L. Johnston. 55 p. 1948. Miscellaneous report 123. Copies on request while supply is available from the Director of Information and Extension, Farm Credit Administration, U. S. Department of Agriculture, Washington 25, D. C.

SUPERVISION

Suggested Outline for Introduction of Supervising Nurses in New York State. Issued by the Bureau of Public Health Nursing, Department of Health, Albany, N. Y. Free of charge to directors of nursing services.

FROM NOPHN HEADQUARTERS

NNAS BOARDS OF REVIEW

The Boards of Review have been approved by the Committee on Unification of Accrediting Activities for the National Nursing Accrediting Service. At present there are four separate boards (1) educational programs in basic noncollegiate (2) basic collegiate (3) public health and (4) other types of postgraduate nursing. Each board has 5 members, all professional nurses competent to evaluate programs in the category of nursing to which they have been appointed. They have been selected to provide a wide geographic distribution.

The Boards of Review members represent primarily nursing education. One more member represents nursing service or the consumer of nursing service, and in the case of the basic programs there is representation from the state boards of nurse examiners. For the postgraduate board the majority are drawn from the field of nursing education since there is need of study and careful evaluation between supplementary and truly advanced programs. When special programs, as industrial nursing or psychiatric nursing and mental hygiene, are being reviewed, two additional members from the special field under consideration will participate in the review.

In all instances an alternate representing the same field of interest has been appointed for each regular board member. Although no regular meeting will be convened with more than one alternate, plans are made for alternates to be kept informed and to participate in various ways.

Each Board of Review is responsible for the evaluation of and authorization for the accreditation of educational programs within its category. In each instance it will make any official recommendations for modification of the program under consideration to the nurse administrator of the educational unit.

To coordinate the activities of the various boards for the service as a whole, an Executive Board of Review has been appointed. This Board is composed of the chairmen of the separate boards and three members-at-large from the Committee on Unification of Accrediting Activities.

The members of the Committee on Unification of Accrediting Activities and the Executive Board of Review are to be found in the Manual of Accrediting Educational Programs in Nursing, Page V, and the functions of all boards on Page 57-58. Their immediate function is the review of annual reports of educational programs in nursing on the 1949 Accredited List. This review with reports of new surveys will form the basis for the 1950 Accredited List.

Members of the Public Health Nursing Board of Review are as follows:

Hazel Higbee, chairman, director of the Bureau of Nursing, Virginia State Department of Health; alternate, Dorothy Wilson, executive director, New Haven (Conn.) VNA. 2 years service.

Eleanor Palmquist, associate professor, Department of Nursing Education, University of Oregon Medical School; alternate, Janet Walker, assistant professor, School of Nursing Education, Catholic University. 2 years service.

L. Ann Conley, associate professor, Wayne University College of Nursing; alternate, Marion I. Murphy, associate professor, School of Public Health, University of Michigan. 1 year service.

M. Olwen Davies, assistant director in education, NOPHN; alternate, Ruth TeLinde, director, Department of Public Health Nursing, Syracuse University College of Medicine. 1 year service.

Irene S. Carn, associate chairman, Department of Nursing, Skidmore College-New York Postgraduate Hospital; alternate, Mrs. Pearl Parvin Coulter, associate professor, School of Nursing, University of Colorado. 3 years service.

COLLEGIATE COUNCIL

The Collegiate Council for Public Health Nursing Education, a section of NOPHN, met in New York, October 21-24. Reports from the various programs indicated trends (1) toward reorganization within the school or administrative unit in the university (2) greater emphasis on basic programs and a need to differentiate between integration of social and health components and specific preparation in public health nursing (3) regional planning in order to share most effectively existing resources and (4) interest in members of the group in the application of research methods to the solution of problems in public health nursing education.

The Collegiate Council is composed of representatives from the programs of study that have been approved for public health nursing by the National Nursing Accrediting Service.

Joint meetings were arranged with the NOPHN Education Committee and the Council of State Directors of Public Health Nursing. This helped to mobilize group thinking in areas of overlapping interest and more clearly to focus on areas of specific interest and responsibility.

NOPHN EDUCATION COMMITTEE

A general business meeting and an executive committee meeting of the Education Committee were held in New York October 23-24, as well as the joint meetings with the Collegiate Council and Council of State Directors referred to above.

Katharine Faville, chairman, told of her observations abroad while consultant to the U. S. delegation at the World Health Organization meeting in Rome in June. She stated her belief that American nurses, because of their educational and economic advantages, have a greatly needed and most worth-while contribution to make to world health.

The Education Committee discussed the increased need for experimentation and research in all nursing education, and especially in public health nursing. Concern was expressed that in our emphasis on broadening the fundamental base of knowledge of *all* nurses, we do not lose track of the special requirements for the practice of public health nursing.

The executive committee reviewed the extensive program for 1950 presented by the secretary. They voted that priority be given to the study of curricula for the preparation of graduate nurses and the publication of an overall statement on public health nursing preparation. A more detailed account of this meeting will appear in the January issue.

KATHARINE TUCKER RETIRES

With forty years of distinguished service in nursing and other social welfare programs to her credit, Katharine Tucker retired in July 1949 as director of the Department of Nursing Education of the University of Pennsylvania. A graduate of Vassar College, Miss Tucker took her basic training in nursing at Newton Hospital Training School in Massachusetts, receiving her diploma in 1910. From 1916 to 1929 she was general director of the Visiting Nurse Society of Philadelphia, and from 1929 to 1935, general director of NOPHN. In 1935 she was appointed to the position with the University of Pennsylvania where she remained until this year.

Paying tribute to Miss Tucker, Ruth W. Hubbard, president of NOPHN, says: "Succeeding generations of public health nurses and their patients will best estimate Miss Tucker's outstanding contributions to public health nursing. To all of us who have worked with her as staff members, colleagues, or students certain qualities of hers and the benefits we have derived from them will live in our hearts and we hope, in our work.

"For me they are pre-eminently Miss Tucker's creative imagination, her keen analytical mind, an eager approach to problems, an alert awareness of other points of view, a respect for individuals coupled with great fairness, even generous, giving of herself to public health nursing and the recurrent joy of her laughter."

Miss Tucker gave freely of her time and effort to professional nursing affairs. She was president of the Pennsylvania Organization for Public Health Nursing in 1918-19; first vice president of the NOPHN from 1916-19. She has served on many important NOPHN committees.

MORE ON RESEARCH STUDIES

In September (page 477) we listed recent studies by university students. The large number of inquiries about them which the universities have received indicates the great interest in research in public health nursing.

The University of Chicago has asked us to clarify the information given in relation to Penelope Hope's thesis "Health Educator and the Public Health Nurse in Health Education."

Studies completed after June 1948, including Mrs. Hope's, may be secured on positive microfilms which must be read with a microfilm reading machine. The charge is 2.5 cents a page plus 25 cents service fee. These studies may also be purchased as positive paper prints (8½ by 11 inches) at 20 cents a page. Only studies completed before June 1948 are available on inter-library loan, and are not available on positive microfilm prints.

Send orders to the Department of Photographic Reproduction, University of Chicago Library, Chicago 37, Illinois.

SEPTEMBER REPRINTS

Reprints from the September magazine are as follows: "Advanced Programs of Study in Public Health Nursing" (Free); "An Automobile Plan for Nurses" by Jerome Apfel (10 cents); and "Nursing the Child With Rheumatic Fever" by Sabra S. Sadler (15 cents). Members are entitled to one copy each without charge.

AGENCYFUL OF "EARLY BIRDS"

First agency to report 100% staff membership in the NOPHN for 1950 is the Metropolitan Life Insurance Company Nursing Service, Memphis, Tennessee. Congratulations! We'll be looking for reports of more 100%ers for listing in coming issues.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
NOPHN *Regional Conferences, Richmond, Va.—Dec. 6, 7, and Indianapolis, Ind., Dec. 13, 14*	
Anna Fillmore Lucy Blair M. Olwen Davies Ruth Fisher Dorothy Rusby Jean South Marie Swanson Edith Wensley	These staff members will represent NOPHN at one or both of the regional conferences
Other Field Trips	
Lucy Blair	Oklahoma City, Okla.—Dec. 15-17 Little Rock, Ark.—Dec. 18-20
Dorothy Rusby	San Francisco, Calif.—Dec. 5-9

November field trips arranged after the November magazine went to press included visits to Boston, Mass., by Anna Fillmore; Syracuse, N. Y., by Jean South; and Yonkers, N. Y., by Marie Swanson.

ABOUT PEOPLE YOU KNOW

In September Leonard W. Mayo became director of the Association for the Aid of Crippled Children; Mrs. Alice Fitz Gerald, associate director. . . . Ruth E. Mettinger, director of nursing of the Florida Board of Health since 1934, was named president of the Florida Public Health Association for the coming year. . . . Mrs. Mildred B. Beck, acting executive secretary of the New York Committee on Mental Hygiene of the State Charities Aid Association, has accepted the position of executive director of the Child Study Association of America. She will succeed Mrs. Sidonie Matsner Gruenberg who retires on January 1. . . . Abbie G. Whidden is the new director of the St. Louis Visiting Nurse Association, succeeding Emilie G. Robson, who retired this past June. . . . Dr. Harry E. Kleinschmidt, noted for his work in the field of health education, was awarded the annual Elizabeth Severance Prentiss National Award by the Cleveland Health Museum, the sixth of these presentations.

Two appointments are announced by the Rochester (N. Y.) VNA—Muriel Guntert as educational supervisor, Marian Negus as assistant district supervisor.

Two new visiting nurse associations have been established in New Jersey: the Somerset Valley VNA at Somerville with Marie G. Gemeroy as director and the Camden VNA at Camden, Mabel Chrystie, director.

NEWS AND VIEWS

NURSING EDUCATION CONSULTATION PROGRAM

By the first of the year Dean Margaret Bridgman will begin to visit colleges and universities who wish to discuss with her their plans for establishing a program in nursing or developing an existing one. Dean Bridgman of Skidmore College, as announced in the June PHN, has been appointed by the Russell Sage Foundation, for a two-year period as a special consultant in the field of nursing education. There have already been many requests for her services, and since final itinerary plans will be made soon and the two-year limit of the service necessitates careful consideration of time and distance, it is important that other institutions wishing to have her services make their requests early in order to be included when she visits the region in which they are located.

Dean Bridgman is concerned that there should be a clear understanding of her function and outline it briefly as follows:

I conceive of my function as a consultant in collegiate nursing education to be that of an agent, first collecting and then sharing ideas, information, and practical suggestions. For the collection part of this process, I am visiting a number of collegiate schools of nursing of varying types and recognized standing, for intensive study of policies and practices. I am also studying current professional literature and conferring with representatives of the national nurses' organizations and of the United States Public Health Service, with secretaries of the state boards of nurse examiners, and with other individuals prominent in the field. This material will of course be supplemented constantly on my travels as I learn of interesting and progressive experiments in many institutions.

For the sharing part of the process, I shall visit colleges and universities requesting my services, and make available to them any of this data which is applicable to the particular situation or of interest to the group. In this capacity, it will not be my function to make speeches, but rather to discuss specific local problems with the trustees, administrators, and faculties of colleges and schools of nursing, contributing to such discussions whatever suggestions I can from the experience and thought of others. The problems are extremely complex and there is no one accepted pattern of excellence. The development of the profession requires continuous experimentation along varied lines and a constant exchange of ideas and experience. I hope to be helpful as a sort of itinerant clearing-house.

The problems lie in many areas, such as: the status of the school of nursing in the university; the relationship to the school of medicine and other schools within the university; the agreements with one or more hospitals and other community agencies; teaching personnel and faculty organization; the complex prob'ems of costs and financing; the curriculum, involving the balance and integration of general, professional, and clinical education; student welfare, including counselling, health, housing, community government, recreational facilities. Local situations differ very widely and these and other problems must be worked out on a local basis, with, however, a clear realization of the urgency of establishing high professional standards which will win general recognition.

My approach from the point of view of educational administration rather than from that of nursing itself imposes limitations of which I am well aware, but may have certain advantages in objectivity. I come to my task with a deep and long-standing interest in nursing education and with appreciation of its values in comparison with those of other programs—liberal arts, pre-professional, and vocational—preparing for other fields. My years of association with a department of nursing within the college of which I am dean, has given me an understanding of the special problems involved in combining academic and clinical education.

My present experience in visiting classes, wards, and clinics in various schools and in conferring with nursing educators in acquainting me with many practical problems and a variety of policies, organizational patterns, techniques, and practices. It is also deepening my respect for the responsibilities and opportunities of nursing as a profession and the unlimited scope of its potential contribution to human betterment through expanding social and health programs.

In a sense I am a "free lance" consultant, under the auspices of the Foundation, representing the point of view of institutions of higher education rather than that of nursing education alone. However, I am strongly in sympathy with the policies and purposes of the nursing organizations, and consultations with national, regional, and state advisors will enable me to coordinate my services with the general program through which the profession is making such notable progress.

NEW CHILDREN'S BUREAU CONSULTANTS

Five top-notch authorities in highly specialized fields of maternal or child health have been appointed part-time consultants in the Children's Bureau. Their primary responsibilities will be to advise the Bureau staff and state health agencies on problems relating to their special fields.

Dr. Harry H. Gordon, professor of pediatrics at the University of Colorado, will be available for consultation on premature programs; Dr. William G. Hardy, director of the Hearing and Speech Center at Johns Hopkins, on hearing and speech problems of children; Dr. Meyer A. Perlstein, professor of pediatrics at the Cook County Postgraduate Medical School in Chicago, on cerebral palsy; Dr. Grete L. Bibring, chief of psychiatric service at Beth Israel Hospital in Boston, on mental health aspects of state child health programs; and Dr. John Whittredge, Jr., assistant professor of obstetrics at Johns Hopkins, on the extension of obstetric services, particularly in rural areas.

"This service marks a new departure in consultation provided by the Children's Bureau in that it will begin to make available throughout the country top-quality medical advice in these fields, heretofore available in only a few states." Dr. Leona Baumgartner, associate chief of the Bureau, explained. "With these consultants available, more states will be able to improve the quality of care provided in their maternal and child health and crippled children's programs."

ABBIE ROBERTS WEAVER AWARD

The Georgia Organization for Public Health Nursing has established a memorial to the first director of public health nursing, Mrs. Abbie Roberts Weaver. The memorial is to take the form of an annual achievement award to the staff nurse working in Georgia who, over and beyond the requirements of her position, has done the most to improve nursing service and advance public health nursing.

The first award will be presented at the annual meeting in 1950. A committee has been appointed to activate recommendations for this memorial. The details of the plan were presented at the annual meeting in Columbus, Georgia, November 7, by Theodora Floyd, chairman of the committee.

AMERICAN CANCER SOCIETY MEETS

Dr. Detlev W. Bronk, president of Johns Hopkins University, told delegates to the American Cancer Society's annual meeting on October 28 that the Society "is performing a great humanitarian service by enabling every American to become a partner in the conquest of cancer."

Some 300 delegates attended a dinner at the Park Sheraton Hotel to hear the noted biophysicist. Hedwig Cohen represented NOPHN.

"Scientists fortified by the instrument and facts of modern science are helpless in their crusade against cancer without financial assistance," said Dr. Bronk. "The compassion of generous men and women for their less fortunate fellows is of no avail against the destructive forces of this dread disease without the help of science.

"Accordingly, the American Cancer Society is performing a great humanitarian service by enabling every American to become a partner in the conquest of cancer. Its activities exemplify some of the finest characteristics of American democracy, for our nation has been made great by the self-determined action of individuals who are conscious of their social obligations.

"It is proper that local, state and federal governments which have responsibility for the welfare of their citizens should guarantee financial support of medical care and research, but in a democracy this support should supplement not supplant direct support by individuals who are thus made conscious of their role in a great humanitarian undertaking."

FOREIGN STUDY UNDER FULBRIGHT ACT

One thousand or more Americans will be given opportunity to undertake graduate study, teaching, or research abroad during the academic year 1950-51 under the terms of the Fulbright Act. Approximately one quarter of the awards are open to visiting lecturers, advance research scholars, and specialists in various professional fields, including medicine, public health, nursing, dentistry and the basic sciences. Countries now participating in the Fulbright program include Belgium, Luxembourg, Burma, Greece, Italy, the Netherlands, Norway, New Zealand, the Philippines, the United Kingdom and British Colonial dependencies, and France.

The awards are made under Public Law 584, 79th Congress, the Fulbright Act, which authorizes the Department of State to use certain currencies and credits acquired through the sale of surplus property abroad for programs of educational exchange with other nations. Awards are ordinarily made for one academic year, although applications will be considered for periods of not less than six months. Grants for teaching or research usually include roundtrip transportation, a basic allowance or stipend, a supplemental allowance when dependents accompany the grantee, and a small sum for necessary equipment. All grants under the Act are made in foreign currencies.

Competition for awards for the academic year 1950-51 closed on November 30, 1949. Requests for information regarding future awards should be addressed to the Committee on International Exchange of Persons, Conference Board of Associated Research Councils, 2101 Constitution Avenue, Washington 25, D.C.

See page 670 for information about WHO fellowship program.

FACTS ABOUT NURSING, 1949

Information on important developments in nursing, contained in *Facts About Nursing, 1949*, was released by the ANA in November. An important feature of the new *Facts* is the data on the inventory of professional registered nurses conducted by the ANA in 1949. The population per active professional registered nurse is shown by a shaded map and reveals that in 1949 five states had only 1 nurse for 995-1997 population while five states had 1 nurse for every 270-324 residents.

The new edition of *Facts* contains a wealth of information on distribution, counseling and placement, and employment conditions of nurses which has been collected from the American Hospital Association, American Medical Association, United States Public Health Service, American Red Cross, and various governmental agencies. Additional material was provided by the statistical departments of the national nursing organizations which cooperated in compiling this book. Copies can be secured from the American Nurses' Association, 1790 Broadway, at 50c per copy.

SNA WINS VOTE ON BARGAINING

The American Nurses Association has announced that the Washington State Nurses Association on November 4, won a vote of 15 to 6 the election to determine the bargaining agent of professional nurses employed by the Boeing Airplane Company, Seattle, in the first National Labor Relations Board election in which a professional state nurses association appeared on the ballot.

The Association plans to begin contract negotiations immediately with the Boeing Company on behalf of the plant's nurses.

● The first National Conference on the Occupied Countries will be held in the Washington Hotel, Washington, D.C., on December 9 and 10, under the auspices of the American Council on Education. Purpose is to discuss our program for the democratic reorientation of the peoples in areas under U. S. military occupation. What progress has been made to date? What are future prospects? How can we assist and strengthen our government's efforts? What can non-governmental organizations and institutions do to help? How can long-term cultural links be established between American agencies and those in occupied countries.

Margaret Arnstein, Ruth Freeman, and Ruth Taylor have been invited to represent NOPHN at this important meeting.

● In September the Yale University School of Nursing initiated a 12-months program in advanced psychiatric nursing, leading to an M.S. degree. The program is open to graduates of approved schools of nursing who hold a B.A. and have had additional professional experience in psychiatric nursing and in public health nursing. It prepares the student to work with all types of emotional and behavior deviations and to teach the psychiatric principles involved in the nursing care of any patient, in whatever field she may be employed. Director of the program is Marion E. Russell. She is a graduate of the Yale University School of Nursing and of the New York School of Social Work. She has an M.A. from the University of California in psychiatric social work. She worked as educational director

and supervisor of the VNA of San Francisco, psychiatric social worker and educational consultant for the Red Cross, psychiatric social worker in the California State Department of Mental Hygiene, and psychiatric consultant for the International Institute in California. For further information about the program write the director, School of Nursing, Yale University, New Haven, Conn.

● A 12-months program in psychiatric nursing for graduate nurses has been established in the division of nursing education, Duke University, to begin with the second semester 1949-1950. Its purpose is to prepare graduate nurses for work at the head nurse level in psychiatric units or hospitals, child guidance clinics, and related fields. Applicants must be graduates of an approved nursing school with at least a year of experience as a graduate nurse; must have had student or graduate experience in psychiatric nursing; and must have above average ability as indicated by recommendations, test scores, and personal interviews. A limited number of stipends are available through the Public Health Service.

For further information write Louise Moser, director of program, Box 3439, Duke Hospital, Durham, North Carolina.

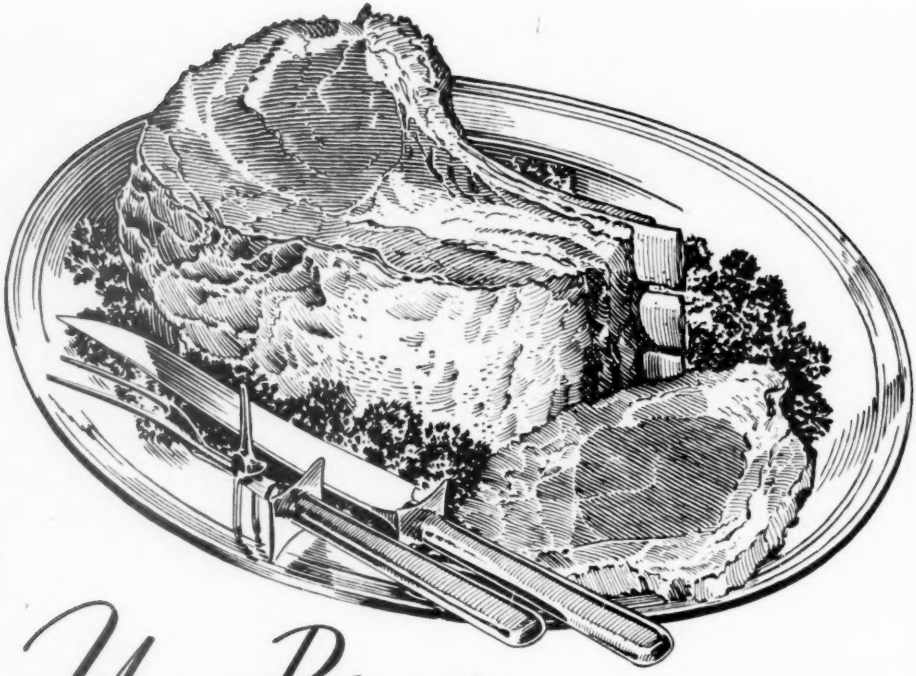
● National Social Hygiene Day will be observed on February 1, 1950. For the kit of program and publicity aids which is available to social hygiene societies and committees and other groups planning to observe the day, write the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

● The International and Fourth American Congress on Obstetrics and Gynecology will take place at the Hotel Statler, New York City, May 14-19, 1950. Distinguished medical authorities from this and other countries will present papers.

Separate afternoon programs are being arranged for nurses by Margaret A. Losty of New York, and for public health people by Dr. Edwin F. Daily of Washington.

● A National Conference on Cardiovascular Diseases will be held January 18-20, 1950, at the Mayflower Hotel, Washington, D. C. Physicians, scientists, community service leaders and members of allied professions, including nursing, will meet to formulate a program for combating and controling heart diseases.

Marion W. Sheahan, director of the National Committee for Improvement of Nursing Service, is a member of the conference Steering Committee.



Your Patients...

And the Meat They Eat

The established relationship between sound dietary planning and a state of maintained good health emphasizes the nutritional importance of meat, man's favorite protein food.

Not only does meat taste good, but of greater significance, it provides a host of nutritional benefits. Developments in the field of nutrition* have proved that complete protein—the kind that meat supplies in abundance—aids in building and maintaining immunity, hastens recovery after acute infectious diseases and following injury and burns, promotes health during pregnancy, aids in the growth and development of husky children, and is needed to maintain everyone in top physical condition.

No matter from what walk of life your patients come, and whether their pocketbooks demand economy or permit satisfaction of that urge for the fanciest cuts, meat gives them full value for their money.

ACCEPTED
COUNCIL ON FOODS AND NUTRITION
AMERICAN MEDICAL ASSOCIATION

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

American Meat Institute

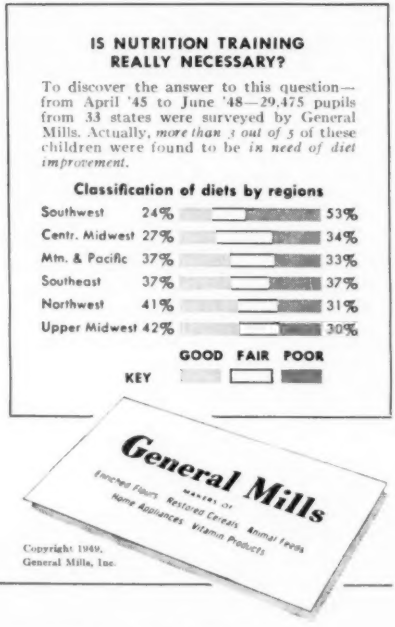
Main Office, Chicago...Members Throughout the United States

The puppet that taught school

George, a versatile hand puppet, came to school one day with a bright idea. After showing how much he liked orange juice, he urged all the children to try some. And that's how the mid-afternoon fruit juice program started at Dryden-Freeville Central School in Dryden, New York. The next day George returned with a spot on his suit. That was a cue for both puppet and children to learn the proper use of paper napkins. Under his amusing tutelage the youngsters learned many valuable lessons in nutrition and table manners.

Using basic materials and ideas supplied through General Mills "Program of Assistance in Nutrition and Health Education," teachers the country over are constantly devising dramatic ways like this to increase their pupils' interest in good eating habits. General Mills has become a kind of central exchange for these ideas. If you have devised a simple and effective way to encourage your children to improve their diets, you can share it with other teachers by writing to General Mills.

If you would like help in setting up nutrition study in your class, within your existing curriculum, write to: Education Section, Public Services Department, General Mills, Inc., Minneapolis 1, Minn.



POSITIONS AVAILABLE

WANTED—Public health nurses—public health certificate preferred; $232 per month if certificated, with increase to $244 after six months; must have car, 7c a mile allowed; 40 hour week.

Public health nurse supervisor—college graduate, must be certificated and have two years experience in public health nursing; must have car, 7c a mile allowed; $256 a month with increase to $269 after six months; 40 hour week. Contact: County Civil Service Office, 242 Third Street, San Bernardino, California.

WANTED—Public health staff nurses for county department of public health. Generalized nursing service for population of approximately 63,000 in rural community. Salary range $280-$300; transportation provided. Public health nursing certificate and experience preferred. Two weeks vacation; two weeks sick leave; 40 hour week. Write: Director of Public Health Nursing, Merced County Health Department, P.O. Box 1350, Merced, California.

WANTED—Public health nurses for positions on all levels in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57th Street, New York 19, N. Y.

WANTED—By January 1st. Public health nursing supervisor for a non-official agency which accepts student affiliates. Applicant should have preparation and experience which meet NOPHN standards; ability to carry on in-service program of staff education a requisite. Retirement plan; beginning salary $3,000. State qualifications and date available. Apply: Executive Director, Manchester Visiting Nurse Association, 194 Concord Street, Manchester, New Hampshire.

WANTED—Supervisor of public health nurses for County Health Department with generalized public health nursing program including three crippled children's clinics and five otological clinics each year. Three weeks study leave every other year. State retirement system. Qualifications: Bachelor's Degree, public health nursing credential with course of eight months in supervisoral training and at least one year's experience in public health nursing on a generalized public health program. Opening salary $300 with increases to $329.00. Must own car; mileage 8c. Write: R. O. Ingham, M.D., County Health Department, 842 Front Street, Santa Cruz, California.

WANTED—Three qualified public health nurses for county health department—35 miles from San Francisco. Generalized program, urban and rural area. Car allowance $600.00 a year. Salary $3,276-$3,660. Write: Director of Nursing, Vallejo-Solano County Department of Public Health, 228 Broadway, Vallejo, California.

New York City needs public health nurses. Vacancies in Health Department. Generalized service including maternal and child care, school health and communicable disease control. Immediate appointment on provisional basis. Starting salary $2400; 37 hour week; liberal vacation allowance; in-service training. Write: Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

WANTED—Graduate nurses for general duty in 237 bed hospital. Starting salary $165 per month plus one meal; $15 differential for 11:00 p.m.-7:00 a.m.; 48 hour week, 21 days vacation. Apply: Director of Nursing, Arnot Ogden Memorial Hospital, Elmira, N. Y.

WANTED—Two qualified public health nurses for generalized program. Salary $2436-$2808; 40 hour week; 30 days vacation with pay; sick leave; retirement plan. Apply: Director, Starr Centre Association, 58 E. Haines Street, Philadelphia 44, Pa.

WANTED—One public health nursing supervisor for staff of 10 nurses in generalized program in city health department. Salary range—$278 to $333. Three staff nurses—salary range—$266 to $319. Write: Public Health Nursing Division, City Health Department, Room 200, City Hall, Sacramento, California.

WANTED—Public health nurses for a number of County Health Departments in Oregon. Salary $240 to $300 per month to start. Some counties furnish transportation. Merit status, vacation and sick leave, retirement. Write: Oregon State Board of Health, 1022 S. W. Eleventh Avenue, Portland 5, Oregon.

WANTED—Qualified public health nurses having, or eligible for, California registration and certificate in Public Health Nursing. Must own and drive car and be willing to live in city. Generalized public health program. City of 100,000. Salary $265-$311. Send full particulars and recent photograph to City Manager, Richmond, California.

WANTED—Orthopedic supervisor and generalized supervisor for well established community chest affiliated public health nursing agency. Staff of 35—3 supervisors; educational director and 2 administrators; graduate student program; retirement plan in operation; liberal personnel policies including five day week. Preparation in public health nursing and physical therapy required for the orthopedic supervisor; preparation and experience as a supervisor or an assistant for the generalized supervisor. Salary open. Apply: Miss Ella L. Pensinger, Executive Director, District Nursing Society, 8 Chestnut Street, Worcester, Massachusetts.

WANTED—Supervisor for staff of three nurses. Visiting nurse work and clinic activities. Minimum salary $3200.00; 40 hour week; 30 days vacation with pay; sick leave; retirement plan. Requirements: College degree with post graduate work in public health; staff nurse experience. Write: Mrs. Fred Wallenta, Stratford Visiting Nurse Association, Stratford, Connecticut.

WANTED—Qualified public health nurses, Monroe County Health Department. A generalized public health nursing program in a semi-rural county, 68,000 population; located near Detroit, Toledo and Ann Arbor. Salary $3,000.00 plus automobile allowance. Write: Medical Director, T. W. Mahoney, M.D., 218 E. First Street, Monroe, Michigan.

WANTED—Well qualified Public Health Nurses to work in a new Bi-County Health Department planning a field training program. Present salary range $2,940-$3,060. To be increased as soon as training program is established. Car allowance $600 a year. Vacation one month. Reply: Dale E. Sholz, M.D., Lawrence-Wabash County Health Department, Lawrenceville, Illinois

Public Health Nursing

INDEX

Volume 41

Year 1949

Official Organ

of the

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.
1790 Broadway, New York 19, N. Y.

INDEX

The following abbreviations are used in this index:
(abs.) abstract
(book rev.) book reviewer
(ed.) editorial
(exc.) excerpt
(n) news note
(rev.) book review

INDEX

INDEX

INDEX

J

K

L

INDEX

N

INDEX

INDEX

R

INDEX

HOPKINS
NOPHN STYLE
UNIFORMS

Unexcelled!

TO ORDER . . . Give style number, height, weight, dress size, hat size. Enclose $20.00 deposit on suit or coat order, $2.00 dress or cap order. Balance C.O.D.

055D—Double-breasted Box Coat
044S—Single-breasted Box Coat
022G—Double-breasted Fitted Coat

All three are not only rainproofed and fully lined with Skinner's "Sunbak" satin, but are "Boconized" — guaranteed 5 yrs. mothproof. Choice of fabric—Elastique, (heavy weight) or Whipcord (medium weight) Stock sizes 10 to 46 — regulars, shorts, longs. **$60.00**

Custom-tailored, if necessary—10% extra. Sleeveless red wool zippered-in-lining. **$10.00**
(can be ordered at any time)
Beret—**$4.50**; Overseas Cap—**$3.50**

N-3 Navy Blue Nylon Dress **$13.50**
S-2 Cramerton Seersucker Dress ..... **$ 8.45**
(Beret—$2.25; Overseas Cap—$1.75)
P-1 Simpson's Soulette Poplin ..... **$ 8.45**

01GS Navy Blue Gabardine Suit **$45.00**
All wool and "Boconized" (mothproof.) Stock sizes 10 to 46. Regulars, shorts, longs.
Custom-tailored 10% extra. Extra skirt $17.50

HOPKINS TAILORING CO., 107 W. FAYETTE ST., BALTIMORE 1, MD.

Smart NOPHN *Twosome*

Double-Breasted

WINTER BOXCOAT
With Zip-In Lining

NOPHN Style 485 is a magnificent "lifetime" coat. Made of Navy Blue All Wool Elastique outer material and mothproofed by Bocanize Process. Fully lined with Skinner's satin-faced wool-back lining. Convertible collar. Complete All Wool Flannel detachable zip-in lining with famous Talon zipper. Sizes 32-46.

Specially Priced at $67.50
(including zip-in lining)

NOPHN Style 480 is superb for Fall and Spring. Same as Style 485, without the zip-in lining. Sizes 32-46.

Only $57.50

NOPHN Style 04
- Matching All-Wool Cap
- Small, Medium, Large $3.50

ORDER NOW

Immediate Delivery

Year 'Round Uniform in

NAVY BLUE BROADCLOTH

NOPHN Style 666B Broadcloth is silky-soft, unexcelled for wearability. Made of luxurious combed all-pima yarn and sanforized to ensure perfect fit. Extraordinary value. Sizes: 10-20, 40-46.

Only $9.95

Also Available in:
POPLIN Style 666-P ..... $ 7.95
NYLON Style 666-N $12.95

VISIT OUR SHOPS

NEW YORK
PITTSBURGH
DETROIT
CHICAGO
BALTIMORE

BRUCKS

Mail Orders To:

Dept. PH-12
387 Fourth Avenue
New York 16, N. Y.

—ASK FOR FREE CATALOG—

CURRENT PERIODICAL SERIES

PUBLICATION NO.: 1714

TITLE: PUBLIC HEALTH NURSING

VOLUME: 42 ISSUES: 1-12

DATE: Janu[redacted]ber 1950

University Microfilms, Inc., Ann Arbor, Mich.